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ABSTRACT

This book provides an overview of family planning and fertility in the United States, from the number of babies women have to the risks they face in having them and the measures they choose to avoid pregnancy, to the dollars that would be saved with fewer unwanted pregnancies. Based on the social science literature through mid-1997, which is cited throughout, the book uses lists and charts to provide nuggets of facts about this area of human behavior. It is appropriate for health educators, family planning practitioners, and others seeking a handy reference guide to basic fertility information. The sections on "Education and Contraception" (p.20), "Education and Ethnicity" (p.68), "Education and Delayed Childbearing" (p. 69), and "College Education and Delay" (p. 70), are of particular interest to educators. (Contains 18 figures and 39 references.) (Author/SLD)

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JUST THE FACTS

FAMILY PLANNING AND FERTILITY IN THE U.S.

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Rodolfo A. Bulatao, Ph.D.

JUST THE FACTS

FAMILY PLANNING AND FERTILITY IN THE U.S.

by

RODOLFO A. BULATAO, Ph.D.

Layout Design by Michael Carley, M.A.

PREFACE

This book provides a concise overview of family planning and fertility in the U.S.—from the number of babies women have, to the risks they run in having them and the measures they choose to avoid pregnancy, to the dollars saved with fewer unwanted births. Based on the social science literature as of mid-1997, the book provides easily digestible nuggets of facts about this intimate but important area of human behavior.

American fertility behavior is changing. Still it remains remarkably inefficient, with more than half of all conceptions being unintended by the partners, and most of these occurring despite the use of contraception. There is much to be said for privacy and romance in this area, but it is also important to understand fertility and contraception as social phenomena, with large consequences for individual lives and for the society as a whole.

Each observation in this book is documented with a reference. Facts change, and our hope is that laying out these facts here will encourage others to try to change them for the better. We also hope it will encourage continued study of how and why Americans choose to regulate or not to regulate their childbearing as they do and how these patterns are gradually changing.

This book serves as a companion to a earlier report issued by Sociometrics, also entitled *Just the Facts,* that focused on teenage sexuality and pregnancy in the U.S.

March 1998

J.J. Card, Ph.D.
President
Sociometrics Corporation

TABLE OF CONTENTS

Chapter I: Family Planning 1
Extent of use 1
Nonuse 2
Sharing responsibility 3

Chapter II: Contraceptive Methods 5
Common methods 5
Sterilization 6
Sterilization at younger ages 7
Who choose sterilization 7
Experience and sterilization 8
Vasectomy 9
Choice of vasectomy 10
Oral contraceptives 10
Failures with the pill 11
Improper use of the pill 11
Distrust of the pill 12
Condoms 13
Condom effectiveness 14
Regular use 14
Other methods 15
Contraceptive implants 16
Emergency contraception 17

Chapter III: Contraceptive Use 19
Contraception at first intercourse 19
Education and contraception 20
Income and contraception 20
Ethnicity and contraception 21
Method failure 21
Failure rates 22
Typical contraceptive costs 22
Cost of not using contraception 23
Costs versus benefits 24

Chapter IV: Fertility 25
Births 25
Birth rates 25
Fertility trends 26
Why fertility swings up and down 27

Chapter V: Fertility intentions 29
Birth expectations 29
Expectations and future fertility 31
Changes in expectations 31
The two-child family 32
Planned and unplanned pregnancies 33
Birth spacing preferences 33
Unintended pregnancy 34
Variation in unintended pregnancies 35
Unintended births 36
Mistimed and unwanted births 37
Abortion after unintended pregnancy 39
Reducing unintended pregnancies 40

Chapter VI: Family Growth 41
Timing of childbearing 41
The economy and childbearing 41
Delayed childbearing 42
Fertility by birth order 43
Second and third births 43
Effects of early childbearing 44
Fertility by age 45
Intercourse 46
Cohabitation 47
Effects of cohabitation 48
Marriage patterns 48
Marriage versus cohabitation 49
First marriage 50
Divorce 50
Remarriage 51
Births outside marriage 52
Nonmarital and marital births 52
Abortion 53
Pregnancy outcomes 55
Immigrant status and outcomes 56
Birth risks and outcomes 56
Unintendness and outcomes 57
Multiple births 58
Infertility and infecundity 58
What affects fecundity 59
Adoption 60
Availability of children for adoption 61

Chapter VII: Fertility Contrasts 63
Fertility of ethnic groups 63
Ethnic births by state 64
The future of ethnic differences 65
More ethnic differences 66
Fertility by religion 67
Fertility by education 67
Education and ethnicity 68
Education and delayed childbearing 69
College education and delay 70
Women's work and fertility 71
Staying on the job with children 72
Work at home and other alternatives 72
Male views 73

Chapter VIII: Physician Services 75
Physician visits for contraception 75
Specialist services 75
Limits on services 76
Who visit physicians 77
Whom they visit 78
Reasons for visits 79
Vasectomy services 79
Physician payment 80
Medicaid clients 81

Chapter IX: Clinic Services 83
Service needs 83
Service options 84
Clinic visits 84
Family planning clinics 85
Client base 85
Distribution of clinics 86
Family planning agencies 87
Client characteristics 88
Hours and staff 89
Routine clinic services 90
Contraceptive methods provided 91
Agencies providing more choice 92
Outreach services 93
Other health services 94

Chapter X: Funding of Services 97
Federal funding 97

Federal/state Medicaid funding 98
Federal Title X funding 99
Federal block grants 100
State and local funding 101
Private funding 101
Funding issues 102
Fees 103
Impact of public subsidies 104
Impact of clinics 105
Savings from public services 105

References 107

Tables

Major contraceptive methods 112
Reported annual public expenditure on contraceptive services per woman in need, by state 114

Figures

1. Percent using contraceptive methods, by age 115
2. Proportion sterilized among men aged 20–39 and their wives 115
3. Percent relying on condoms, by woman's marital status 116
4. Percent relying on condoms, by woman's age 116
5. Method choice by income, shown as percent of the poverty line 117
6. Five-year cost of contracepting and not contracepting 117
7. Trends in total fertility and crude birth rate 118
8. Actual births and births expected for women by age in 1988 118
9. What is to blame for unplanned pregnancies: Adults' opinions 119
10. Pregnancies per woman and their outcomes, by ethnic group 119
11. Births per thousand women, by age and ethnic group 120
12. Total fertility for Black and White women 120
13. Births per thousand women, by age and education 121
14. Proportion of women working, and working with a young child 121
15. How clients pay physicians (percentages) 122
16. Clinic size (based on clients) by agency and number of clinics 122
17. Percent of counties without family planning clinics, by state 123
18. Intended, unintended, and averted births and abortions 123

CHAPTER I
FAMILY PLANNING

How many births a woman typically intends to have	2.2	Mosher & Bachrach 1996:7
How many years a woman would have to contracept after having the last child she wants	Typically 15 years or more	Mosher & Bachrach 1996:6

Extent of use

Number of women using (or whose partner is using) contraception	34.5 million in 1990	Peterson 1995b:2
Recent trend in contraceptive use	Upward from 1982 to 1988, from 56 percent to 60 percent of women aged 15–44, then slightly downward to 59 percent in 1990	Peterson 1995b:3

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Nonuse

Whether nonusers want to become pregnant	Only one out of ten nonusers does.	Peterson 1995b:3
What about the other nine	Seven out of ten nonusers are unlikely to get pregnant—because they are already pregnant, recently pregnant, sterile, or not having intercourse. The remaining two out of ten are "taking chances," not wanting to become pregnant but not using contraception.	Peterson 1995b:3
Whether "taking chances" is becoming more common	From 1988 to 1990, the proportion "taking chances" among women 15–44 (i.e., not contracepting despite wanting to avoid pregnancy) went from 5 to 8 percent.	Peterson 1995b:3
Who take chances more often	Young women, those never married, White women	Peterson 1995b:3

Sharing responsibility

Whether sexually active adults believe their own partners take enough responsibility for preventing unplanned pregnancy	Yes, in nine out of ten cases	Delbanco et al. 1997:73
Whether women hold this view less often than men	No. Differences between men and women are negligible.	Delbanco et al. 1997:73
But do they believe that men in general are sufficiently responsible	No. Three out four consider men irresponsible in this area (and more women do so than men).	Delbanco et al. 1997:73

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CHAPTER II
CONTRACEPTIVE METHODS

Common methods

Most common means of contraception among women and men combined	Sterilization Oral contraceptives Condoms (See Table for method list)	42% 24% 18%	Mosher & Bachrach 1996:6 World Bank 1993:90–95
How method choice changes as a woman ages	Sterilization is increasingly likely to replace oral contraceptives. Condom use is fairly constant across age groups (see Figure 1).		Peterson 1995b:6
Most common contraceptive among younger women	Oral contraceptives, commanding 61 percent of users among 18–19-year-olds and 55 percent of users among 20–24-year-olds		Mosher & Bachrach 1996:6

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Sterilization

Why sterilization is popular	It is effective, final, and women do not fear side effects,	Mosher & Bachrach 1996:6
Ratio of those depending on female sterilization to those depending on male sterilization	5:2	Mosher & Bachrach 1996:6
Number of women sterilized	10.2 million in 1990, 17.5 percent of women aged 15–44	Peterson 1995b:3
Proportion relying on sterilization among women who want no more children	70 percent	Mosher & Bachrach 1996:6
By what age sterilization becomes the leading contra-ceptive method for women	By 30–34, because most women have had all the children they want by that age	Mosher & Bachrach 1996:6
Growth in reliance on female sterilization	From 22 percent of all users in 1982 to 30 percent in 1990, to become the leading method not only among women 30 and over but also among less-educated women, those with lower income, and minority groups	Mosher & Bachrach 1996:6

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Whether sterilization will continue to increase	Probably, because of the aging of the baby-boom generation	Peterson 1995b:3

Sterilization at younger ages

Proportion sterilized among younger married men (20–39 years old)	12 percent	Forste et al. 1995:103
Proportion of these men whose wives are sterilized	13 percent (see Figure 2)	Forste et al. 1995:103

Who choose sterilization

Whether race affects choice of sterilization	Yes. Blacks are 60 percent *less* likely to choose sterilization than Whites.	Forste et al. 1995:104
Whether Catholics chooses sterilization less than Protestants	Yes. The husband's religion is more important than the wife's, when their religions differ. But having the same religion leads to more sterilizations than having different religions.	Forste et al. 1995:104

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How education affects sterilization	Wife's education has no effect. Husband's education has a complicated effect: having a high school education favors sterilization, but have a post-high school education makes this choice less likely.	Forste et al. 1995:104
Does remarriage increase the likelihood of sterilization	Yes. When both partners are previously married, the likelihood that one is sterilized is more than three times the likelihood in a first marriage.	Forste et al. 1995:104

Experience and sterilization

What previous experience leads to sterilization	An unintended pregnancy. Couples who had not intended to have the last pregnancy are three times as likely to have chosen sterilization than couples whose last pregnancy was deliberate.	Forste et al. 1995:105
Does this mean that couples choose sterilization when other methods fail	Sometimes. But this is true more often when the failed method was a male method or one requiring the husband's cooperation.	Forste et al. 1995:105

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Vasectomy

Number of couples relying on vasectomy in 1990	4.4 million	Peterson 1995b:3
Number of vasectomies in 1991	493,487	Marquette et al. 1995:645
Proportion of men 25–49 having vasectomies in that year	1 percent	Marquette et al. 1995:645
In what region vasectomies are most common	The Midwest, where the rate is 65 percent higher than in the Northeast or South	Marquette et al. 1995:646
Why vasectomy is more popular there	One explanation suggested is its availability, with the emergence of strong residency training programs for family physicians in the Midwest. Before this, rates used to be higher in the West.	Marquette et al. 1995:648

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Choice of vasectomy

Whether method failure affects the choice of vasectomy over female sterilization	Male method failure favors choosing vasectomy.	Forste et al. 1995:105
Whether Blacks favor vasectomy	Definitely not. Only one in ten Black couples who rely on sterilization have chosen vasectomy.	Forste et al. 1995:105
Whether choice of vasectomy is related to the ages of the couple	In a way. Vasectomy is less likely if the husband is more than three years older than the wife.	Forste et al. 1995:10

Oral contraceptives

Number of users of oral contraceptives	9.9 million in 1990, or 17 percent of women aged 15–44	Peterson 1995b:3
Groups relying more on oral contraceptives	College-educated White women	Mosher & Bachrach 1996:6

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Failures with the pill

Proportion of women who get pregnant within one year using oral contraceptives	7 percent	Mosher & Bachrach 1996:6
Proportion of *married* women who get pregnant within one year using oral contraceptives	3 percent	Potter et al. 1996:154
Proportion who get pregnant in one year when using oral contraceptives properly	0.5 percent	Potter et al. 1996:154

Improper use of the pill

How often women miss a pill, in the first cycle (the first month) after prescription	Two out of three, in one study, failed to take at least one pill when they should have. And one out of three missed three or more pills.	Potter et al. 1996:156

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How often women miss a pill by the third cycle	Four out of five missed at least one pill, and half missed at least three.	Potter et al. 1996:156
Why compliance with the pill regimen gets worse over time	The reason has not been established, but perhaps women learn to make up for missed pills, learn what mistakes can get away with, or simply grow fatigued with conscientious pill-taking.	Potter et al. 1996:157
Are those who eventually discontinue pill use more likely to miss a pill	There is no evidence of this.	Potter et al. 1996:157
What days of the week are women most likely to miss a pill	Friday and Saturday	Potter et al. 1996:156

Distrust of the pill

Proportion of women who believe oral contraceptives fails at least one in ten times	About 40 percent, whereas about 60 percent of adults consider it "very effective"	Murphy et al. 1995:95 Delbanco et al. 1997:72
Whether distrust of oral contraceptives has gone up	Yes. In 1983 only 31 percent were of this opinion. Distrust of all other methods has also gone up.	Murphy et al. 1995:95

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Whether women see substantial health risks from use of oral contraceptives	More than half of women do, including more than half of those who have attended college	Murphy et al. 1995:95
Whether they see health benefits from using oral contraceptives	Of those with an opinion, half do and half don't. The most common reported benefit is regulation of menstrual periods.	Murphy et al. 1995:95
Whether they favor over-the-counter sales of oral contraceptives	86 percent of women do not, including 91 percent of those actually using orals	Murphy et al. 1995:95

Condoms

Number of women relying on condoms	6.1 million	Peterson 1995b:2
Proportion relying on condoms	10.5 percent of women aged 15–44 in 1990, up from 6.7 percent in 1982	Peterson 1995b:2
Who are using condoms more often now	Younger women under 35, and especially under 25, and the unmarried (see Figure 3 and 4)	Peterson 1995b:2
Why condom use increased in these groups	Probably because of concern about HIV	Mosher & Bachrach 1996:6

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How condom use relates to education	It is more common among the more educated, but has increased recently, among the less educated.	Peterson 1995b:2

Condom effectiveness

How effective adults think the condom is at preventing pregnancy	38 percent of adults consider it "very effective"	Delbanco et al. 1997:72

Regular use

Whether those relying on condoms use them every time they have intercourse	More than half do not. Those using condoms to avoid pregnancy more often used it consistently than those using condoms to prevent disease.	Peterson 1995b:10
What most distinguishes women occasionally using condoms from women not even considering it	Partner support for condom use and the belief that it is a wise choice (among inner-city minority women)	Santelli et al. 1996:104
Whether having multiple sexual partners leads to more condom use	No and yes: not with the main partner, but with other partners (among inner-city minority women)	Santelli et al. 1996:104–105

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What most distinguishes women using condoms regularly over six months from those using them occasionally	Believing condoms build trust with the main partner, finding them easy to use, and not using other contraceptive methods (among inner-city minority women)	Santelli et al. 1996:104

Other methods

The next most common "barrier" method, after the condom	The diaphragm, with 990 thousand users, or 1.7 percent of women aged 15–44	Peterson 1995b:3
Other barrier methods	The female condom, the sponge, the cervical cap, spermicides. Their use is too infrequent for national surveys to provide good estimates.	Peterson 1995b:3
Methods that do not require drugs or devices	Periodic abstinence, relied on by 930 thousand women, and withdrawal, relied on by 350 thousand. Using these methods, three out of ten get pregnant in one year.	Peterson 1995b:3
The contraceptive that has almost disappeared from the market	The IUD, still used by 7 percent in 1982, but down to 1 percent (under 500 thousand women) in 1990	Mosher & Bachrach 1996:6

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Contraceptive implants

Advantages and disadvantages of contraceptive implants	They provide continuous protection for up to five years without requiring continuous vigilance, but they do involve minor surgery for insertion and removal. Relative costs are high if they are quickly discontinued.	Kalmuss et al. 1996:256
Likelihood of discontinuing the implant	Among low-income clients of clinics in three cities, 8 percent discontinued within six months, comparable to other reversible methods.	Kalmuss et al. 1996:258
Most common reason given for discontinuing	Menstrual irregularities, although these were equally common among discontinuers and other users	Kalmuss et al. 1996:259
What does distinguish discontinuers from other users	Number of reported side effects, similar dissatisfaction with other methods, a partner who wants a child soon, perceived pressure from the health provider to choose implants, and exposure to negative media coverage	Kalmuss et al. 1996:256

Emergency contraception

What is emergency contraception	Oral contraceptives for use within a short time after unprotected intercourse	Ellertson 1996:44
How effective it is	The best studied method (involving one dose of a combined estrogen-progestin pill within 72 hours of intercourse and a second dose 12 hours later) has an effectiveness rate of at least 75 percent. Since a pregnancy would not necessarily occur in any case, the method fails, meaning it allows a pregnancy to occur, only 0.2 to 2.8 percent of the time.	Trussell et al. 1996:58, 64
How safe it is	Almost all women can safely use it.	Trussell et al. 1996:64.

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CHAPTER III
CONTRACEPTIVE USE

Contraception at first intercourse

Proportion of women using contraception at first intercourse	Over half, regardless of race	Mosher & Bachrach 1996:5
Women more likely to use contraception at first intercourse	Jewish women, women at least 19 years old, women whose mothers went to college, women living with both parents	Mosher & Bachrach 1996:5
Women less likely to use contraception at first intercourse	Hispanic women, White Fundamentalist women, women in communities with fewer economic opportunities	Mosher & Bachrach 1996:5
Most common method at first intercourse	The condom, relied on by 28 percent of users in 1980–82, but by up to 55 percent of users in 1988–90	Mosher & Bachrach 1996:5

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Education and contraception

What methods more educated women rely on more often than less educated women	Oral contraceptives, condoms, vasectomy	Peterson 1995b:8
What method they rely on less often	Tubal ligation	Peterson 1995b:8
Why they choose the methods they do	More educated women delay childbearing with reversible methods.	Peterson 1995b:8
Why less educated women favor sterilization	Because they are likely to have had all the children they want at a younger age.	Peterson 1995b:8

Income and contraception

How income affects contraceptive choice	It appears to provide a broader range of choices. Whereas almost half of contraceptive users close to or below the poverty line rely on tubal ligation, only a quarter of users with higher income (at least three times the poverty level) do so. Instead, at higher income, users of almost all other methods are more numerous (see Figure 5).	Peterson 1995b:7

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Ethnicity and contraception

How contraceptive use varies between Whites and Blacks	Relatively little, with the proportions contraceptive being close to 60 percent in each group	Peterson 1995b:3
Whether the methods they choose differ	Hardly, except in regard to sterilization. Overall, 25 percent of women rely on sterilization in each group. But among Whites at least one of three of these rely on vasectomy, whereas among Blacks less than one in thirty does.	Peterson 1995b:3
How Hispanic contraceptive use differs	Overall, use is slightly lower than Whites or Blacks, at 52 percent, largely accounted for by lower reliance on vasectomy	Peterson 1995b:3

Method failure

Which reversible method fails least often	Oral contraceptives, but when used for one year they still fail 7 percent of the time		Mosher & Bachrach 1996:6
How often other reversible methods fail, over one year of use	Condoms	16%	Mosher & Bachrach 1996:6
	Diaphragms	22	
	Spermicides	30	
	Periodic abstinence	31	

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Whether this means the methods are ineffective	Not necessarily. Often they fail because they are improperly used.	Mosher & Bachrach 1996:6

Failure rates

One-year failure rates for all methods combined (except sterilization)	14 percent	Mosher & Bachrach 1996:6
Failure rates for high-income and low-income women	High-income: 10 percent Low-income: 21 percent	Mosher & Bachrach 1996:6
Which ethnic groups have higher failure rates	Blacks and Hispanics, rather than Whites	Mosher & Bachrach 1996:6

Typical contraceptive costs

Typical cost for a tubal ligation	$1,190–2,470. The low estimate is from the Medi-Cal public program; the high estimate is for managed care.	Trussell et al. 1995:496
Whether vasectomy is cheaper	Definitely. It costs $353–756.	Trussell et al. 1995:496

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Typical cost for oral contraceptives	From $18 to $21 per cycle, plus $17 to $38 for an office visit	Trussell et al. 1995:496
Typical cost for a condom	$0.33–1.00	Trussell et al. 1995:496
Can using contraception save money	Yes, because it helps one avoid unintended pregnancies	Trussell et al. 1995:497

Cost of not using contraception

What unintended pregnancies cost	Carried to term, a pregnancy may cost from $3,600 to $8,600 (under Medi-Cal and under managed care, respectively) for maternity care, delivery, and newborn hospitalization.	Trussell et al. 1995:497
Cost if the pregnancy is not carried to term	The typical cost of an induced abortion is $345–420, of a spontaneous abortion $420–1,040, and of an ectopic pregnancy $2,800–5,000.	Trussell et al. 1995:497
Cost of *not* using contraception for five years	On average, a woman would have 4.25 unintended pregnancies, which, given the usual outcomes for such pregnancies, would cost in total between $6,490 and $14,660. This does not include childrearing costs.	Trussell et al. 1995:496

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Costs versus benefits

Cost of contracepting for five years	Anywhere from $203 to $2,739, depending on the method used (see Figure 6)	Trussell et al. 1995:501
Whether withdrawal and periodic abstinence are cheaper, if not free	No. You have to take into account their high failure rates and the costs of the unintended pregnancies that follow.	Trussell et al. 1995:501
What, therefore, are the cheapest methods to use if you contracept for five years	The Copper-T IUD, followed by vasectomy and implants	Trussell et al. 1995:501
Whether tubal ligations cost too much	They cost more than the majority of other methods, but this cost is still only a fifth of the cost of not using contraception over five years. And a tubal ligation appears cheaper and cheaper as one relies on it for a longer and longer time.	Trussell et al. 1995:501

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CHAPTER IV
FERTILITY

Births

Number of births in 1995	3.9 million	Guyer et al. 1996:1009 cf. Peters 1997:3
Number of births in 1990	4.15 million in 1990, the high point in recent years	Guyer et al. 1996:1009

Birth rates

Birth rate	14.8 births per thousand people in 1995, versus 16.7 per thousand in 1990	Guyer et al. 1996:1009

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Why this rate is also known as the "crude" birth rate	Because it is not adjusted for such things as the number and ages of women in the population	
States with the highest and lowest birth rates	■ *Highest:* Utah (20.3) California (17.8) Texas (17.5) ■ *Lowest:* Maine (11.2) W. VA (11.6) Vermont (11.7)	Guyer et al. 1996:1009
Number of children per woman	The most convenient measure of this is the total fertility rate, which was 2.04 in 1995. This means that a woman whose fertility as she aged followed that of the corresponding age group in 1955 would have 2.04 children in all.	Guyer et al. 1996:1009

Fertility trends

Long-run trend in U.S. fertility since 1917	Down, up, down, up—a low point during the Great Depression, a high point in the baby boom, a still lower point during the baby bust that followed (see Figure 7)	Morgan 1996:21. Figure reprinted with permission.
Low point reached during the depression	Total fertility of 2.1 children in 1936: The birth rate was 18 per thousand.	Morgan 1996:21

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High point reached during the baby boom	Total fertility of 3.7 in 1957, with a birth rate of 24 per thousand. (The birth rate was actually higher, at 27 per thousand, in the one unusual year of 1946.)	Morgan 1996:21
Low point reached during the baby bust	Total fertility of 1.7 in 1976, with a birth rate of 16 per thousand	Morgan 1996:21

Why fertility swings up and down

Theoretically, two main types of influences on fertility swings	■ Period factors, or year-to-year events that affect all women with the potential to have a birth in that period ■ Cohort factors, which differentiate women born in different years	Morgan 1996:22
Relative importance of "period" and "cohort" factors in fertility swings	Period factors have been more important; year-to-year fertility fluctuations have affected all age groups.	Morgan 1996:20
How period factors have affected fertility	Mainly through changing ■ The proportion of women having first and second births ■ The timing of such births	Morgan 1996:24

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Two causes of the baby boom

- Larger proportions of women having at least two children
- Earlier ages at childbearing

Morgan 1996:24

CHAPTER V
FERTILITY INTENTIONS

Birth expectations

Number of births women between the ages of 15 and 44 expect to have	In 1988, 2.22 births In 1982, 2.38 births	Peterson 1995a:2
Actual fertility rate in these years	In 1988, 1.93 In 1982, 1.83	Mosher & Bachrach 1996:8

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Why actual births fell short of expectations—and were higher when expectations were lower	Expectations cover one's reproductive lifetime, whereas fertility rates cover a specific year or range of years. In these years, women were delaying childbearing, expecting to catch up later. At the same time, slightly older women had already completed their childbearing and were therefore contributing little to current fertility.	Mosher & Bachrach 1996:8 Peterson 1995a:9
Does the difference have implications for future fertility	Yes. Future fertility should rise as women now delaying childbearing attempt to reach their expectations.	Peterson 1995a:2
Whether expectations have ever fallen below current fertility	Yes. In the late 1950s, women expected 3.2 births, but current fertility reached 3.7 births. By the time they had completed childbearing, however, these women did in fact have approximately 3.2 births on average.	Peterson 1995a:9

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Expectations and future fertility

How expected number of births compares to a woman's eventual family size	They correspond closely, to the extent comparisons can be made. (Comparisons are still inexact for many of the women who have been surveyed, even as far back as the 1970s, because they could still potentially have more children.)	Peterson 1995a:7
Whose fertility tends to fall short of expectations	Those of unmarried women and of childless women, whether married or not. These groups eventually have only 80 percent of the births they expect when they are 18–25 years old.	Peterson 1995a:8
How expectations change with marriage	They rise slightly and become more accurate predictors of future fertility.	Peterson 1995a:8
How many births married women expect	2.32 in 1988, down from 2.47 in 1982 and 2.80 in 1973	Peterson 1995a:2

Changes in expectations

Whether younger and older women expect different numbers of births	Generally not. Although older women have had more births on average, the total they expect is quite similar to the total for younger women (see Figure 8).	Peterson 1995a:2

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What happens to expected births as a woman ages	In the aggregate, they remain remarkably stable. If they decline, it is by less than 5 percent.	Peterson 1995a:6
Whether birth expectations are stable for Black women	Largely yes. However, young Black women show an unusual pattern. The number of births they expect rises slightly as they age (by around 10 percent), possibly because of early childbearing and the desire to avoid unintended births.	Peterson 1995a:6

The two-child family

Is the two-child family still the norm	Yes. It is what 44 percent of women expect.	Peterson 1995a:8
Whether childlessness is a growing preference	Somewhat. From 1982 to 1988, the proportion expecting to be childless rose from 7 to 9 percent. The proportion expecting one child also rose from 12 to 14 percent.	Peterson 1995a:8
Whether married women increasingly favored childlessness or only one child	No. The increase was only among the unmarried, whose expectations tend to be less reliable predictors of future behavior.	Peterson 1995a:8

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Planned and unplanned pregnancies

Whether couples follow "master plans" for all their births, or whether they plan one birth at a time	Not known; researchers disagree	Morgan 1996:39
What proportion of all pregnancies are planned	Sixty percent of all women giving birth report they were "seeking pregnancy"	Morgan 1996:36
What proportion of teen pregnancies are planned	Forty percent report they were "seeking pregnancy"	Morgan 1996:37

Birth spacing preferences

What is widely considered the appropriate interval between births	2–3 years	Morgan 1996:39
Rationale people give for such an interval	■ To limit the period of intensive childcare ■ To assure children have play-mates	Morgan 1996:39

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Latest national data on such interval preferences	Princeton Fertility Study (1970)	Morgan 1996:39

Unintended pregnancy

Proportion of pregnancies that are unintended	60 percent, totalling 3.3 million in 1988	Kost & Forrest 1995:14
What proportion of these occurred while contraception was being used	47 percent, meaning more than half were due to failure to use contraception	Forrest 1994
Whether unintended pregnancies are a big problem	Nine out of ten adults think so.	Mauldon & Delbanco 1997:26
Where adults most often put the blame for unplanned pregnancy	On decline in moral standards (see Figure 9)	Delbanco et al. 1997:72
Whether this agrees with the view in other countries	No. Canadians and Dutch, for instance, more often blame lack of education.	Delbanco et al. 1997:72

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Variation in unintended pregnancies

At what age a pregnancy is most likely to be unintended	Under 20, when 85 percent are unintended	Kost & Forrest 1995:14
At what age a pregnancy is least likely to be unintended	30–34, when 47 percent are unintended. The proportion unintended rises again after 35, reaching 60 percent for women 40 and older.	Kost & Forrest 1995:14
Whether pregnancies are more likely to be unintended among poor women	Yes. Below the poverty line, three out of four pregnancies are unintended. Just above the poverty line (up to 150 percent of poverty-level income), two out of three pregnancies are unintended. Above that level, half of pregnancies are unintended.	Kost & Forrest 1995:14
Whether Blacks have more unintended pregnancies	More of their pregnancies are unintended than among Whites (80 percent versus 54 percent), but the total of one million unintended pregnancies among Blacks is much smaller than the total 3.8 million unintended pregnancies among Whites. For Hispanics, 63 percent of pregnancies are unintended, totalling 704 thousand pregnancies.	Kost & Forrest 1995:14

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How women who intend to become pregnant differ from those who become pregnant without intending to	They are older—70 percent being 25 or older versus 45 percent among those not intending to become pregnant. They are also less likely to be poor or Black.	Kost & Forrest 1995:12

Unintended births

Proportion of births due to unintended pregnancies	43 percent	Kost & Forrest 1995:14
Why the proportion of births unintended is lower than the proportion of pregnancies unintended	Because half of unintended pregnancies end in induced abortion	Forrest 1994
How the proportion of births unintended changes with age	At ages 15–19, 73 percent are unintended. At ages 20–24, 46 percent are unintended. At ages 25–29, 32 percent are unintended.	Mosher & Bachrach 1996:8

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Among which groups unintended births are more common	Women with little education, low income, older women, and Black women	Mosher & Bachrach 1996:8
Proportion of births unintended among ethnic groups	Whites, 37 percent Blacks, 48 percent Hispanics, 66 percent	Kost & Forrest 1995:14
Trend in unintended births	Slightly upward in the 1980s	Kost & Forrest 1995:14
What groups have shown the greatest increase in unintended births	Poor and less-educated Black women	Mosher & Bachrach 1996:8
Do women below the poverty level want to give birth when they do	Mostly not: 53 percent said they did not want a birth at that time, and an additional 11 percent said they did not want a birth at any time. Thus only 36 percent of births among women below the poverty level were "intended."	Willis & Haaga 1996:79

Mistimed and unwanted births

Why a birth may be unintended	Either the woman did not want a birth at the time she became pregnant (the birth was "mistimed") or she did not want a birth at all (the birth was "unwanted")	Kost & Forrest 1995:14

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Whether mistimed births are more common than unwanted births	Yes, by about 5 to 1	Kost & Forrest 1995:14
Whether mistimed births mainly occur among the young	Yes, but not exclusively. The ratio of mistimed to unwanted births is 8:1 among women under 20, and declines steadily to 1.1:1 among women 35 and older.	Kost & Forrest 1995:14
Whether a never-married woman is more likely to be consider an unintended birth mistimed or unwanted	Mistimed, by about 5.6 to 1. However, this is not much different from the ratio among the married (5.1 to 1).	Kost & Forrest 1995:14
How frequency of mistimed and unwanted births changes as a woman has more children	The proportion of all births mistimed stays the same (between 35 and 40 percent of all births) whether a woman has 0, 1, 2, or 3 or more children. But the proportion of births unwanted rises from 3 to 25 percent.	Kost & Forrest 1995:14
How education affects mistimed and unwanted births	It reduces both, but reduces unwanted births more, suggesting that educated women are better able to avoid births when they don't want them at all. The ratio of mistimed to unwanted births is 4:1 among those with less than 12 years of education, rising to 8:1 among those who have completed college.	Kost & Forrest 1995:14

Abortion after unintended pregnancy

What proportion of all pregnancies ends in abortion	29 percent	Kost & Forrest 1995:13
Whether abortion is a more common consequence of unintended pregnancy among minorities	No. Among Blacks, abortion is equally common as an outcome of unintended pregnancy as among Whites (49 percent). And, among Hispanics, abortion is less common (45 percent).	Kost & Forrest 1995:14
For what age group abortion after an unintended pregnancy is most likely	For the few women with such pregnancies aged 40 or older	Kost & Forrest 1995:14
For what age group abortion after an unintended pregnancy is next most likely	For the more numerous women with such pregnancies under 20 years old	Kost & Forrest 1995:14
Whether abortion is more common after an unintended pregnancy among the poor	The opposite is true. After an unintended pregnancy, 43 percent of women below the poverty line have an abortion, as contrasted with 50 percent of women with more income.	Kost & Forrest 1995:14

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Reducing unintended pregnancies

Can unintended pregnancies be reduced	Probably. Other industrial countries have rates of unintended pregnancies close to half those in the U.S. (i.e., 30 percent).	Mosher & Bachrach 1996:8
How many births would be averted by bringing unintended pregnancies down to this level	200,000 births annually	Mosher & Bachrach 1996:8
How many abortions would be averted	800,000 annually	Mosher & Bachrach 1996:8

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CHAPTER VI
FAMILY GROWTH

Timing of childbearing

What researchers mean by "early childbearing"	Births to women under 20	Morgan 1996:28
What researchers mean by "on-time childbearing"	Births to women 20–29	Morgan 1996:29
What researchers mean by "delayed childbearing"	Births to women 30 and older	Morgan 1996:29

The economy and childbearing

Which type of childbearing is most affected by the state of the economy	On-time childbearing	Morgan 1996:36

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Two reasons why	■ Because women 20–29 are more likely to plan their births than younger women ■ Because they have more leeway to postpone births than older women	Morgan 1996:36
Whether a strong economy means more births	Yes	Matthews et al. 1997:58
Whether it means fewer abortions	No. Abortions are not reduced, but contraception is.	Matthews et al. 1997:58–59

Delayed childbearing

What influences the probability of delayed childbearing	■ Proportion of women still childless at 30 ■ Proportion of these women who then go on to have children	Morgan 1996:37
Which of these two factors is more important	■ Up to 1980, the first factor, the proportion still childless ■ After 1980, the second factor, the proportion who go on to have children	Morgan 1996:37–38

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Fertility by birth order

Proportion of total fertility accounted for by first births	Over 40 percent	Morgan 1996:25
Proportion accounted for by first births early in this century	25 percent	Morgan 1996:25
Proportion accounted for by fourth or higher-order births	10 percent	Morgan 1996:25
Proportion accounted for by fourth or higher-order births early in this century	Over 40 percent	Morgan 1996:25
Maximum proportion of childbearing due to third or higher-order births	25 percent	Morgan 1996:40

Second and third births

How soon women have a second birth	For the majority, within five years of the first birth, but the pace is slowing	Morgan 1996:41

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What the trend is in timing of second births	Of those having a first birth in 1950–59, 80 percent had a second birth within five years; of those having a first birth in 1965–69, 72 percent had a second birth within five years; of those having a first birth in 1975–89, only 63 percent had a second birth within five years.	Morgan 1996:41
What the trend is in timing of third births	Of those having a second birth in 1950–59, 64 percent had a third birth within five years; of those having a second birth in 1965–69, 45 percent had a third birth within five years; of those having a second birth in 1975–89, only 35 percent had a third birth within five years.	Morgan 1996:41

Effects of early childbearing

Effect of an early birth on later childbearing	Increases the pace of subsequent childbearing	Morgan 1996:42
Change in this effect over time	Effect weakened in 1965–73, disappeared by the late 1970s	Morgan 1996:43
Effect of an early birth on completed family size	Increases ultimate family size	Morgan 1996:43

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Change in this effect over time	No verified change. It holds true for all cohorts that have completed their fertility, though it may be weaker for cohorts that are still in childbearing ages.	Morgan 1996:43

Fertility by age

Proportion of total fertility contributed by women 20–29 since 1920	Over 50 percent in every year	Morgan 1996:26
Trend since 1975 in the proportion of total fertility contributed by women 20–29	Downward from 60 percent, the high point in this century	Morgan 1996:26
Current proportion of total fertility contributed by women 20–29	56 percent (in 1993)	Morgan 1996:26
Trend since 1975 in the proportion of total fertility contributed by women 30–39	Upward from 20 percent, the low point in this century	Morgan 1996:26

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Current proportion of total fertility contributed by women 30 and older	30 percent (only 2 percent by women 40 and older)	Morgan 1996:26
Current proportion of total fertility contributed by women under 20	14 percent	Morgan 1996:26

Intercourse

The first time she has intercourse, does a woman want to or not	The majority of women wanted to, but 25 percent said they did not want to though they were not forced to, and 4 percent said they were forced.	Willis & Haaga 1996:79
Who have intercourse more frequently, the single or the married	The married (as well as the cohabiting)	Morgan 1996:44
Frequency of sexual intercourse for married or cohabiting couples in prime childbearing years	4–12 coital acts per month	Morgan 1996:44
Trend in frequency of sexual intercourse	Uncertain; may have increased or may be unchanged over three decades	Morgan 1996:44

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Effect of possible changes in coital frequency on fertility	Probably none; any increase was offset by use of more effective birth control	Morgan 1996:44

Cohabitation

Proportion cohabiting (i.e., living with a sexual partner but not married)	5 percent	Mosher & Bachrach 1996:5
Proportion who have ever cohabited	34 percent of all women of reproductive age (15–44)	Mosher & Bachrach 1996:5
Proportion who have ever cohabited among younger women	45 percent among women 25–34	Mosher & Bachrach 1996:5
When cohabitation occurs	Most often before first marriage	Mosher & Bachrach 1996:5
Does cohabitation vary by race	Not substantially	Mosher & Bachrach 1996:5

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Effects of cohabitation

How long cohabitation usually lasts between one man and one woman	2 years among the never-married 3 years among the formerly married	Goldscheider & Kaufman 1996:88
Does cohabitation restrict your freedom	Yes, said one in three men. Yes, said one in six women.	Goldscheider & Kaufman 1996:88
Is contraception used more, during cohabitation, if the man is affectionate and committed	Yes, and more likely to be used effectively too	Goldscheider & Kaufman 1996:94
Whether children living with a cohabiting couple are the biological children of both	Not for the majority of these children, whether the couple are formerly married or not	Goldscheider & Kaufman 1996:91

Marriage patterns

Number of marriages in 1995	2.3 million, or 8.9 per thousand people	Guyer et al. 1996:1008

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Whether marriage is less popular now	Slightly. In 1990 there were 2.4 million marriages, or 9.8 per thousand people. The long-term trend is a slight decline. There were 10.0 marriages per thousand people in 1915, 11.1 in 1950, and 10.6 in 1980.	Guyer et al. 1996:1008
Does marriage vary by race	Yes; 13 percent of White women 30–34 years old have never married, versus 31 percent of Black women	Mosher & Bachrach 1996:5
Whether it is less common now, among White men, to be married and living with children	Yes. In 1960, White men spent only 65 percent of their years between 20 and 49 married and living with children. By 1980, this had fallen to 52 percent. But Black men were ahead of them, and by 1980 spent only 39 percent of their years married and living with children.	Goldscheider & Kaufman 1996:91

Marriage versus cohabitation

Whether marriage leads to higher fertility than co-habitation	Yes	Morgan 1996:44
Whether this is true for Black women	Yes, but less than for Whites	Morgan 1996:45

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Whether this is true for poorer White women	Yes, but less than for richer White women	Morgan 1996:45

First marriage

Mean age for a woman's first marriage	24.6 years	Mosher & Bachrach 1996:5
Mean age for a man's first marriage	26.5 years	Mosher & Bachrach 1996:5
How much first marriage age rose from 1964 to 1988	3.2 years among women 2.5 years among men	Mosher & Bachrach 1996:5
Why it rose	Because marriage was postponed for work, or replaced with cohabitation	Mosher & Bachrach 1996:5

Divorce

Number of divorces in 1995	1.16 million, or 4.4 per thousand people	Guyer et al. 1996:1008

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Whether divorce is now in decline	Yes, from a rate of 5.2 per thousand in 1980. The long-term trend, of course, has been upward, from a rate of 1.0 per thousand in 1915.	Guyer et al. 1996:1008
Does divorce vary by race	Yes. Ten years after the wedding, 72 percent of White women were still married, versus 62 percent of Black women.	Mosher & Bachrach 1996:5
How divorce is linked to women working	A woman insecure in her marriage is more likely to work, but her working does not make divorce more likely.	Goldscheider & Kaufman 1996:89
How divorce is linked to a man's involvement with children	Greater involvement with children makes a man less likely to divorce.	Goldscheider & Kaufman 1996:95

Remarriage

Does remarriage vary by race	Yes. Within three years of divorce, 44 percent of White women have remarried, versus 20 percent of Black women.	Mosher & Bachrach 1996:5
Effects of such marriage patterns on fertility	Higher nonmarital fertility among Blacks than Whites	Mosher & Bachrach 1996:5

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Births outside marriage

Proportion of White women bearing a child outside marriage	17 percent	Forste & Tienda 1994:114 (1992)
Proportion of Black women bearing a child outside marriage	67 percent, or four times as often	Forste & Tienda 1994:114
Proportion bearing a child outside marriage, for other ethnic groups	Hispanics are intermediate, at 27 percent. Asians are low, at 7 percent.	Forste & Tienda 1994:114

Nonmarital and marital births

Ratio of births outside marriage to births in marriage among Whites	217:1000	Morgan 1996:46 (1991)
Ratio of births outside marriage to births in marriage among Blacks	670:1000	Morgan 1996:46 (1991)

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Trends in these ratios since 1963	Upward. In 1963, the ratio for Whites was 31:1000, for Blacks 258:1000.	Morgan 1996:46
Why these ratios rose from 1963 to 1983	Because the number of single women increased relative to the number of married women, and because marital fertility declined	Morgan 1996:47
Why these ratios continued to rise after 1983	Because, in addition and in this period only, the proportion giving birth among the unmarried increased, part of the reason possibly being a decline in "legitimation," i.e., in "forced" marriages after a pregnancy	Morgan 1996:47
What has happened to "shotgun weddings"	They're less common. Actually force is rarely involved. This type of post-hoc legitimation of childbearing involved 45 percent of unmarried women in the early 1970s but only 27 percent by the late 1980s.	Goldscheider & Kaufman 1996:89

Abortion

Whether U.S. abortion rates are high in comparison to those of advanced industrial countries	No and yes. Not high in comparison to Eastern Europe, where abortion has been the principal means of birth control. But high in comparison to Western Europe and other advanced industrial countries.	Morgan 1996:52

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Whether teenage abortion rates account for high overall abortion rates	Only partly, since other age groups also have high rates	Morgan 1996:52
How credible the sources of abortion data are	■ Most credible: mail surveys of abortion providers ■ Next in credibility: reports from state health departments ■ Least credible: women's own reports on surveys	Morgan 1996:52
Whether credible sources give higher or lower rates	Higher	Morgan 1996:52
Trend in abortion rates since 1980	Downward, from 29 per thousand women 15–44 years old to 26 per thousand by 1992	Morgan 1996:52
Best documented explanation	Decline in access to services	Morgan 1996:52
How great the effect of access is	Between 1988 and 1992, the decline in abortion providers accounted for 24–30 percent of the decline in abortions.	Matthews et al. 1997:58

Pregnancy outcomes

Lifetime pregnancies per woman	3.3 (this is the "total pregnancy rate")	Mosher & Bachrach 1996:7
Typical outcomes for these pregnancies	2.1 births 0.8 abortions 0.4 fetal deaths	Mosher & Bachrach 1996:7
How outcomes vary between ethnic groups	More than a third of Black pregnancies end in abortion, as contrasted with a fifth among Whites and Hispanics. Therefore only half of Black pregnancies end in a live birth, as opposed to almost two out of three among Whites and Hispanics (see Figure 10).	Mosher & Bachrach 1996:7
Frequency of fetal loss	One in six pregnancies, according to surveys, but possibly higher because early miscarriages are often missed	Mosher & Bachrach 1996:7

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Immigrant status and outcomes

Whether the babies of immigrants are less healthy	The opposite is true. When compared with women of the same ethnic group who were born in the U.S., foreign-born women (especially Blacks, Cubans, Mexicans, and Chinese), have fewer infants of low birthweight and fewer who die in infancy.	Singh & Yu 1996
Why immigrants have healthier babies	Less cigarette smoking, less substance abuse, more support from relatives, more breastfeeding, fewer unintended births	Singh & Yu 1996

Birth risks and outcomes

How many pregnant women smoke	15 percent in 1994, down from 20 percent in 1989	Guyer et al. 1996:1011
How many delay prenatal care till the third trimester	4 percent in 1994, the lowest ever (four out of five receive prenatal care in the first trimester)	Guyer et al. 1996:1011
Rate of Caesarean deliveries	One out of five	Guyer et al. 1996:1011

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Proportion of babies of low birth weight (under 2500 g, or 5.5 lbs.)	7.3 percent (but 13 percent among Blacks)	Guyer et al. 1996:1010
Proportion of babies of extremely low birth weight (under 1500 g, or 3.3 lbs.)	1.3 percent (3 percent among Blacks)	Guyer et al. 1996:1010

Unintendness and outcomes

Whether an unintended birth is linked to low birth weight	Yes, and only partly because women with more unwanted births tend to be socioeconomically disadvantaged	Hummer et al. 1995:403
What is more important than whether the pregnancy was intended	Whether the woman is reconciled to and happy about the pregnancy during its course	Sable et al. 1997:80
How ambivalence about a pregnancy affects its outcome	For one thing, ambivalent women are less likely to seek prompt and adequate prenatal care	Sable et al. 1997:76

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Multiple births

Number of multiple births in 1994	97,064 twins 4,233 triplets 315 quadruplets 46 quintuplets or higher	Guyer et al. 1996:1013
Change in the risk of multiple births	Up 33 percent since 1980	Guyer et al. 1996:1013
Change in the risk of triplets, quadruplets, and higher multiple births	From 1 in 2,500 births in the 1980s to 1 in 860	Guyer et al. 1996:1013
Why multiple births are more common now	Because women are having children at later ages, which leads to more multiple births, and because of new fertility-enhancing drugs and techniques	Guyer et al. 1996:1013

Infertility and infecundity

How physicians define infertility	As the inability to conceive after one year of unprotected intercourse (the definition is used to screen couples for treatment)	Mosher & Bachrach 1996:6
Whether infertility has become an epidemic	No. In fact, infertility among married couples has not increased since 1965.	Mosher & Bachrach 1996:6

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How physicians define impaired fecundity	As including infertility, but also including difficulty or danger in carrying a baby to term	Mosher & Bachrach 1996:6
Whether impaired fecundity is epidemic	No. The proportion of couples with impaired fecundity, 8 percent in 1982, was still 8 percent in 1988. The proportion did not change for women of any age or parity.	Mosher & Bachrach 1996:6
So why does the popular perception exist that infertility has increased	· Because women are attempting to conceive at older ages, when they are less fecund · Because the number of these women is unusually large due to the baby boom · Because the media have paid much attention to new fertility drugs and techniques	Mosher & Bachrach 1996:6

What affects fecundity

How impaired fecundity rises with age	Among childless women, impaired fecundity affects: · 4 percent at ages 15–24 · 13 percent at ages 25–34 · 21 percent at ages 35–44	Mosher & Bachrach 1996:6
What does *not* affect impaired fecundity	Neither race nor income has any effect.	Mosher & Bachrach 1996:6

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What does affect impaired fecundity	Having had pelvic inflammatory disease	Mosher & Bachrach 1996:6

Adoption

Proportion of ever-married women who have ever adopted a child	About 2 percent, little changed in two decades	Mosher & Bachrach 1996:8
Who are more likely to adopt children	It varies depending on whether the adopter and adoptee are related.	Mosher & Bachrach 1996:8
Who are more likely to adopt related children	Black families and those with low income and education	Mosher & Bachrach 1996:9
Who are more likely to adopt unrelated children	Childless women or those with fertility impairments, Whites, and those with more education and income	Mosher & Bachrach 1996:8
Proportion of couples with fertility impairment who have ever taken any steps toward adoption	11–24 percent	Mosher & Bachrach 1996:9

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Availability of children for adoption

What proportion of births outside marriage are available for adoption	Only 3 percent in 1982–88, down from 19 percent in 1965–72	Mosher & Bachrach 1996:9
Why availability has fallen	Initially, because of increases in abortion; later, because of the diminishing stigma of unwed parenthood	Mosher & Bachrach 1996:9
Ratio of adoption-seekers to actual adoptions	3.3 to 1	Mosher & Bachrach 1996:9

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CHAPTER VII
FERTILITY CONTRASTS

Fertility of ethnic groups

Of the 3.9 million babies in 1995, how many were White (non-Hispanic)	2.4 million, or 62 percent	Guyer et al. 1995:1008
Who were the other babies	670 thousand Hispanics 600 thousand Blacks 160 thousand Asians and Pacific Islanders 38 thousand American Indians	Guyer et al. 1995:1008

Whether this means Whites had the highest fertility	No, actually Whites are near the bottom. Over her lifetime, a White woman would have one birth fewer than a Hispanic woman, based on 1995 rates.	Guyer et al. 1995:1008
How the fertility rates of these groups compare	Hispanics had the highest rate in 1995, at 3.01 births per woman, followed by Blacks (2.30), American Indians (2.08), Whites (1.99), and Asians and Pacific Islanders (1.94). For the population as a whole, the rate was 2.04 births per woman.	Guyer et al. 1995:1008
Whether the proportion of Hispanic births is increasing	Yes, from 14 percent of the total in 1990 to 17 percent of the total in 1995	Guyer et al. 1995:1010
At what stage of childbearing ethnic groups differ	Mainly in number of first births at young ages. The proportion still childless at age 25 is about twice as high among Whites as among African Americans (see Figure 11).	Morgan 1996:49 Guyer et al. 1995:1008

Ethnic births by state

What state had the most White babies in 1995	California (at 458,000), more than half again as many as Texas (280,000), and more than twice as many as New York (195,000)	Guyer et al. 1995:1008

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Where half of all Hispanic babies are born	In the two states of California (248,000) and Texas (140,000). New York follows at 53,000.	Guyer et al. 1995:1008
What states had the most Black babies	New York 55,000 Florida 42,000 California 40,000	Guyer et al. 1995:1008
Where half of all Asian-Pacific Islander babies are born	In the three states of California (60,000), New York (13,400), and Hawaii (12,900)	Guyer et al. 1995:1008
Whether non-White babies are a majority in any state	Yes. In Hawaii, White babies were only 27 percent of the total. In the District of Columbia also, White babies were only 22 percent of the total.	Guyer et al. 1995:1008

The future of ethnic differences

Whether fertility is converging across ethnic groups	No. For instance, while White and Black total fertility have each fallen by almost two children since the 1960s, a gap of roughly half a child has persisted (see Figure 12)	Morgan 1996:48. Figure reprinted with permission.

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Whether ethnic differences in fertility are large enough to produce substantially different growth rates	Yes. By 2050, African Americans and Hispanics would be 30 percent more numerous (and Native Americans 50 percent more numerous) if their fertility does not converge to that of Whites.	Morgan 1996:49

More ethnic differences

Whether differences in fertility exist among Hispanic groups	Yes. Fertility is higher among women of Mexican and Puerto Rican origin, lower among women of Cuban origin (whose fertility is below that of Whites).	Forste & Tienda 1996:114
Whether higher fertility among Mexican immigrants is due to having more births before coming to the U.S.	No. Women of Hispanic origin have larger families because of childbearing *after* immigration.	Forste & Tienda 1996:114
How Asian-Americans differ among themselves in fertility	Vietnamese have the highest, Chinese and Japanese the lowest.	Forste & Tienda 1996:114

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Fertility by religion

Whether Catholics or Protestants have higher fertility	Among White women, Catholics had higher fertility until the 1980s. Protestants then began having higher fertility, and now have 1.91 lifetime births, versus 1.64 births among White non-Hispanic Catholics.	Mosher & Bachrach 1996:8
Why this is so	Catholics marry later and less often than Protestants.	Mosher & Bachrach 1996:8
How other religious groups compare	Mormons have high fertility, Jews and the nonreligious low.	Mosher & Bachrach 1996:8

Fertility by education

Whether women with more education have fewer births	Generally yes, with exceptions. In 1994, women with 13–15 years of education had only three-fourths the number of births as the national average. But women with 16 or more years of education had 6 percent more births than the national average.	Mathews & Ventura 1997:9

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What accounts for the most educated women having many births	In that particular year, many of these were older women catching up after delaying childbearing	Mathews & Ventura 1997:9
At what age women with 12 years or less of education have the highest birth rate	At 20–24 (see Figure 13)	Mathews & Ventura 1997:9
At what age women with 13–15 years of education have the highest birth rate	At 25–29	Mathews & Ventura 1997:9
At what age women with 16 or more years of education have the highest birth rate	At 30–34	Mathews & Ventura 1997:9

Education and ethnicity

Whether late childbearing among educated women is true only among Whites	No. It is also typical among Blacks, Hispanics, and Asians and Pacific Islanders	Mathews & Ventura 1997:9

74

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Whether education accounts for higher fertility among Blacks than Whites	No. At all educational levels except the highest, Blacks have higher fertility.	Mathews & Ventura 1997:4
Whether education accounts for higher fertility among Hispanics	No. At practically all education levels, Hispanics have higher fertility than either Whites or Blacks.	Mathews & Ventura 1997:4
Whether the fertility of different groups becomes more similar with more education	Yes, especially for education beyond 12 years	Mathews & Ventura 1997:9

Education and delayed childbearing

Change in total fertility from 1973 to 1988	None. In both years, total fertility was 1.9.	Rindfuss et al. 1996:277

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Change in the fertility pattern	Dramatic. Younger women had substantially fewer births by 1988, older women substantially more. For instance, women aged 15–19 had 10 percent fewer births in 1988 than in 1973, whereas women 35–39 had 26 percent more births in 1988 than in 1973. The increasing delays are still continuing.	Rindfuss et al. 1996:277
Whether the delays occur at all levels of education	Yes, though they are much less evident at lower levels and substantially greater at higher levels.	Rindfuss et al. 1996:284

College education and delay

Whether this is because mean years of education among the college-educated is rising	No	Rindfuss et al. 1996:285
Whether the delay only affects first births	No, it affects births of all parities.	Rindfuss et al. 1996:287
Whether the greater delay among the college-educated is due to later marriage	Only partly	Rindfuss et al. 1996:287

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What is causing the delay	An increasing range of jobs for women and greater availability of childcare	Rindfuss et al. 1996:288
How the greater delay among the college-educated is affecting children	Children in more educated households have a growing advantage over children in less educated households, as their parents are increasingly more mature and financially stable.	Rindfuss et al. 1996:288

Women's work and fertility

Whether a woman's working and her childbearing are related	Yes. Childbearing reduces employment in the short run, hindering a woman's working. In the long run, employment reduces childbearing.	Rosenfeld 1996:199
Trend in female employment	Upward, from 14 percent in 1900 to 55 percent by 1994	Rosenfeld 1996:200
Typical lifetime employment pattern for women after World War II	The "M" pattern: employment after school and before marriage, then staying home to raise children, return to work after children are grown, and finally retirement	Rosenfeld 1996:201
Change in the pattern since then	Women born after World War II generally do not quit work to raise children (see Figure 14)	Rosenfeld 1996:202

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Who began doing this first	Black women	Rosenfeld 1996:202

Staying on the job with children

How often a woman avoids an "employment gap" when she has her first child	One of out five avoids an employment gap by not leaving her job. She may however go on maternity leave.	Rosenfeld 1996:204
How quickly new mothers return to work	43 percent return within 3 months 69 percent are back in 12 months 86 percent eventually return	Rosenfeld 1996:204
Do salary or wages affect staying on the job	Yes. Women who contribute a greater share of family income are less likely to leave their jobs, and if they do, they return to work more quickly.	Rosenfeld 1996:204

Work at home and other alternatives

Do employed women with children tend to work at home	To some extent yes, if their children are under 14, and more so (up to 21 percent of the time) if their children are under 6.	Rosenfeld 1996:209

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Do women with children tend to work part-time	Somewhat, but with children aged 14–17, 54 percent of employed women (whose husband was present) still worked full-time. With children under six, 38 percent worked full-time.	Rosenfeld 1996:209
Whether divorced women with children tend to work longer hours	Yes. With older children, three out of four still work full-time, and even with young children, over half work full-time.	Rosenfeld 1996:209
How often do grandparents look after children	For 26 percent of families with children under 19	Rosenfeld 1996:203

Male views

Whether greater involvement in a career makes a man less positive about parenthood	Yes	Goldscheider & Kaufman 1996:95
Do men think family planning is a joint responsibility	Two-thirds of young men thought so in the 1980s, as opposed to only one-third of adolescent males in the 1970s	Grady et al. 1996:221

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Who decides whether to have sex, according to the men	The majority have an "egalitarian" perspective, meaning that they do not pick one sex over the other. But those who do pick either sex tend to pick women three times as often as men.	Grady et al. 1996:222
Which men emphasize more the role of the man in such decisions	Hispanics. By contrast, men who were cohabiting with their partners emphasized the role of the woman in these decisions.	Grady et al. 1996:224
Whether men believe they should be responsible for contraception	More than three out of four had an egalitarian view.	Grady et al. 1996:223
Who are more likely to believe the woman should be responsible.	Blacks and those with less than a high-school education. Even among these groups, however, the majority had an egalitarian view.	Grady et al. 1996:224
Whether men believe they should be responsible for the children they father	Nine out of ten agree.	Grady et al. 1996:223

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CHAPTER VIII
PHYSICIAN SERVICES

Physician visits for contraception

Annual number of visits to private physicians for contraception, as reported by clients	24.5 million (in 1988)	Landry & Forrest 1996:203
Annual number of visits to private physicians for contraception, as reported by physicians	13.5 million (in 1990–92)	Landry & Forrest 1996:205

Specialist services

Obstetricians providing reversible contraceptives	100 percent	Landry & Forrest 1996:203

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General and family practitioners providing reversible contraceptives	84 percent	Landry & Forrest 1996:203
Specialists performing sterilization	94 percent of obstetricians-gynecologists, 18 percent of general practitioners, 89 percent of urologists	Landry & Forrest 1996:203
Proportion of clients served by obstetricians-gynecologists	Two out of three	Landry & Forrest 1996:203

Limits on services

Whether obstetrician-gynecologists and general practitioners provide contraceptives to minors	35 percent do not do so without parental consent	Forrest & Samara 1996:188
Whether they accept Medicaid reimbursements for contraceptive visits	50 percent do not	Forrest & Samara 1996:188

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Whether they reduce fees for women who cannot afford the cost of family planning services	64 percent do not	Forrest & Samara 1996:188

Who visits physicians

Proportion of family planning visits by women and by men	94 percent versus 6 percent	Landry & Forrest 1996:205
Proportion of all physician visits by women aged 15–44 that involve contraception	7 percent	Landry & Forrest 1996:205
Proportion of female contraceptive visits involving women under 30	61 percent	Landry & Forrest 1996:205
Proportion of male contraceptive visits involving men under 30	21 percent	Landry & Forrest 1996:205

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Physician visits by women in which a reversible contraceptive is provided	66 percent (and four of five times this is an oral contraceptive)	Landry & Forrest 1996:205
Physician visits by men in which a vasectomy is performed	38 percent (other visits are probably to prepare for or follow up on the procedure)	Landry & Forrest 1996:205
Proportion of visits that are repeat visits	Women: 83 percent Men: 58 percent	Landry & Forrest 1996:205

Whom they visit

What specialists women see	Obstetrician-gynecologist (69 percent of visits) or general practitioner (21 percent)	Landry & Forrest 1996:205
What specialists men see	Urologist (43 percent) or general practitioner (23 percent)	Landry & Forrest 1996:205

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Reasons for visits

How often family planning in general or a specific contraceptive is cited by the client as the specific reason for a visit	Among women, 19 percent of the time Among men, 36 percent of the time		Landry & Forrest 1996:205
What other reasons women give	General medical exam	15% of visits	Landry & Forrest 1996:205
	Gynecological exam or Pap test	13	
	Prenatal or postpartum visit	12	

Vasectomy services

Who perform vasectomies	Urologists do 72 percent, family physicians 15 percent, and general surgeons 13 percent.	Marquette et al. 1995:645
How much experience specialists get in the procedure	Among urology practices, close to half perform 50 procedures a year; in the other two groups, most of those who performed the procedure did fewer than 25 a year.	Marquette et al. 1995:645

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Are vasectomies mainly an office procedure	Yes, 99 percent of the time. Three out of four are performed in physicians' offices, most of the remainder in hospital outpatient settings.		Marquette et al. 1995:646
Whether the regions differ in services	Somewhat. For instance, 90 percent of vasectomies in the West are performed in physicians' offices, as opposed to only 68 percent in the Northeast.		Marquette et al. 1995:647
What methods of vasectomy are used	Ligation	35%	Marquette et al. 1995:647
	Cautery	23	
	Clips	12	
	Combinations of these	30	
Is local anesthesia sufficient	Three-fourths of the time nothing else is used. The rest of the time, local anesthesia is supplemented with sedation.		Marquette et al. 1995:647

Physician payment

Most common source of payment	Private insurance or managed care (covering 60 percent of all visits)	Landry & Forrest 1996:205
Other sources of payment	Medicaid or other government program (12 percent of visits), clients' own funds (22 percent) (see Figure 15)	Landry & Forrest 1996:205 Landry & Forrest 1996:204

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Medicaid clients

Age of Medicaid clients, as contrasted with private insurance and managed care clients	About five years younger	Landry & Forrest 1996:206
Ethnicity of Medicaid clients	Medicaid clients are four times as likely to be Black, twice as likely to be Hispanic.	Landry & Forrest 1996:206
Length of Medicaid visits	30 percent spent more than 20 minutes with the physician, versus 40 percent when payment was through private insurance or managed care	Landry & Forrest 1996:206
How services differed on Medicaid visits	On 56 percent of Medicaid visits, the physician provided a contraceptive (versus 64 percent on visits paid through private insurance or managed care). On 32 percent of Medicaid visits, a Pap test was performed (versus 55 percent on visits paid through private insurance or managed care).	Landry & Forrest 1996:206

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CHAPTER IX
CLINIC SERVICES

Service needs

Women seeking family planning services annually	18–20 million, or a third of all women aged 15–44	Frost 1996:92 Mosher & Bachrach 1996:9
Women receiving services from subsidized family planning clinics	6.6 million (estimated for 1994)	Frost 1996:95
Whom researchers consider to be in need of subsidized family planning services	Women at risk of unintended pregnancy whose family income is less than 2.5 times the poverty level	Frost 1996:98
Proportion of women in need of subsidized family planning services who received them	44 percent	Frost 1996:95

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Service options

Type of providers that users of family planning services rely on	Private doctor or HMO	64% of users	Mosher & Bachrach 1996:9
	Federally funded (Title X) clinic	18	
	Other clinic	18	
Main benefits they receive, beyond contraception, when they use these services	Screening for cancer and hypertension, which 90 percent of these women receive each year, as opposed to variable proportion among other women		Mosher & Bachrach 1996:9

Clinic visits

Proportion of women seeking services who visit a family planning clinic	36 percent	Frost 1996:92
Proportion of women depending on a clinic among those with family incomes below poverty level	60 percent	Frost 1996:92

Proportion of women depending on a clinic among those younger than 20	62 percent	Frost 1996:92
Primary reason for dependence on a family planning clinic rather than a private physician	Lower cost: many clinics are subsidized and offer free or reduced-cost services	Frost 1996:92

Family planning clinics

Number of publicly funded family planning clinics	7,054 (in 1994)	Frost & Bolzan 1997:6
Location of clinics	53 percent are in metropolitan counties	Frost 1996:94

Client base

Average number of contraceptive clients per clinic	923	Frost 1996:95

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Average per clinic in metropolitan areas	1,290	Frost 1996:95
Average per clinic outside metropolitan areas	505	Frost 1996:95
Type of agency with the most clients per clinic	Planned Parenthood affiliate, with 2,074 clients per clinic on average (see Figure 16)	Frost 1996:95 Frost 1996:94–95

Distribution of clinics

Proportion of counties with at least one subsidized clinic	85 percent	Frost 1996:97
Counties least likely to have a subsidized clinic	Smaller counties with fewer than 1,000 women in need of subsidized care	Frost 1996:97
States where over 40 percent of counties have no clinic	Nebraska, North Dakota, South Dakota, Alaska, Montana (see Figure 17)	Frost 1996:97
States where at least 60 percent of women in need are served by subsidized clinics	Alaska, Connecticut, Delaware, Mississippi, Montana, New Hampshire, Vermont, West Virginia	Frost 1996:99

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States where fewer than 35 percent of women in need are served by subsidized clinics	Hawaii, Illinois, Louisiana, Nebraska, Ohio, Utah	Frost 1996:99
Number of women in need served at clinics supported by Federal family planning funds (called Title X, which is explained under *Funding* below)	4.2 million (in 1994)	Frost 1996:99

Family planning agencies

Number of publicly funded family planning agencies	3,119 (in 1995), some operating more than one clinic	Frost & Bolzan 1997:7
Most common type of such agency	Health departments (45 percent of the total)	Frost & Bolzan 1997:9

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Other types of family planning agencies	Hospitals	17% of agencies	Frost & Bolzan 1997:9
	Community and migrant health centers	16	
	Planned Parenthood affiliates	5	
	Independent agencies	16	
Which type of agency focuses most on family planning	Planned Parenthood affiliates (with 80 percent of clients receiving contraceptive services), followed by independent agencies (65 percent)		Frost & Bolzan 1997:8
Which type of agency focuses least on family planning	Community and migrant health centers (17 percent of clients received contraceptive services), followed by public health departments (35 percent) and hospital outpatient departments (45 percent)		Frost & Bolzan 1997:8

Client characteristics

Proportion of contraceptive clients 20 and older	70 percent (only 20 percent are 30 and older)	Frost & Bolzan 1997:8
Proportion of clients who are White	61 percent	Frost & Bolzan 1997:8

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Proportion with family incomes below the poverty level	57 percent	Frost & Bolzan 1997:8
Proportion with family incomes below 2.5 times the poverty level	90 percent	Frost & Bolzan 1997:8

Hours and staff

Average wait for an appointment for routine contraceptive care	10 days, from scheduling an exam to date of appointment	Frost & Bolzan 1997:8
Agencies with the shortest waiting time	Planned Parenthood clinics—4 days	Frost & Bolzan 1997:8
Proportion providing extended clinic hours	Nearly half of agencies have evening appointments; fewer than one in five have weekend hours	Frost & Bolzan 1997:8
Proportion of agencies that follow up on clients who miss a visit	Three out of four agencies follow up	Frost & Bolzan 1997:8
Amount of physician care provided per agency	6–8 hours per week on average	Frost & Bolzan 1997:8

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Amount of midlevel clinician care or nursing care provided per agency	71 hours per week on average	Frost & Bolzan 1997:8

Routine clinic services

Most frequent type of contraceptive client visit	Initial visit and annual contraceptive visit	Frost & Bolzan 1997:8
Routine services provided on such visits	Pap smears Breast and pelvic exams Blood pressure measurement Education on effective method use Education on breast self-examination	Frost & Bolzan 1997:8
Proportion of agencies routinely providing such services	100 percent	Frost & Bolzan 1997:8
Proportion of agencies that routinely obtain sexual histories	94 percent	Frost & Bolzan 1997:8

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Other tests provided (and proportion of agencies providing them routinely)	Hematocrit and hemoglobin tests	75% of agencies	Frost & Bolzan 1997:8
	Tests for gonorrhea	64	
	Tests for chlamydia	54	
	Tests for syphilis	42	
	Pregnancy tests	on request	
Additional topics of counseling (and proportion providing them routinely)	Risk factors for sexually transmitted diseases	96% of agencies	Frost & Bolzan 1997:8
	Condom negotiating skills	62	
Special approaches to counseling (and proportion providing them routinely)	Video education	77% of agencies	Frost & Bolzan 1997:8
	Group education sessions	36	

Contraceptive methods provided

Only contraceptive method provided by all agencies	Oral contraceptives		Frost & Bolzan 1997:8

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Other contraceptive methods provided by at least 90 percent of agencies	Injectable		Frost & Bolzan 1997:8
	Male condom		
	Spermicide		
	Diaphragm		
Other methods that may be provided on site, and proportion of agencies providing them	Periodic abstinence	78% of agencies	Frost & Bolzan 1997:9
	Implant	59	
	IUD	47	
	Emergency contraception	38	
	Female condom	30	
	Tubal sterilization	28	
	Vasectomy	23	
	Cervical cap	20	

Agencies providing more choice

Type of agency providing most methods	Planned Parenthood affiliate (10 methods on average, versus 7–8 for other agencies)	Frost & Bolzan 1997:9

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Relation of Title X federal funding (see *Funding* below) to methods provided	Agencies with Title X funding more often provide the more commonly available reversible methods, especially spermicides, diaphragms, and male condoms (the latter often for free); less often provide the less commonly available methods, especially emergency contraception and sterilization		Frost & Bolzan 1997:9
Areas where more methods are available	Metropolitan rather than rural areas; the Northeast and West rather than the Midwest and South		Frost & Bolzan 1997:9

Outreach services

What hard-to-reach groups are routinely served, by what proportion of agencies	Disabled women	40% of agencies	Frost & Bolzan 1997:10
	Men	39	
	Substance abusers	37	
	Homeless women		
	Prison inmates	35	
		11	
What proportion of agencies provide special programs for adolescents	69 percent		Frost & Bolzan 1997:10

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Special adolescent programs provided (and proportion providing them)	Contraceptive education in schools or youth centers	49% of agencies	Frost & Bolzan 1997:10
	Programs to postpone sexual activity	43	
	Programs including male partners	37	
	Incentive programs to avoid pregnancy	15	

Other health services

Other reproductive health services provided for female clients by at least half of all agencies	Postpartum care Prenatal care Infertility counseling	Frost & Bolzan 1997:11
Other non-reproductive health services provided for female clients by at least half of all agencies	Nutrition counseling Immunizations Well-baby care WIC program Sports or work physicals	Frost & Bolzan 1997:11

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Other health services provided for male clients by at least half of all agencies	None	Frost & Bolzan 1997:11
Other health services provided for male clients by a third to a half of all agencies	Sports or work physicals Testicular cancer screening Primary health care Prostate cancer screening Infertility counseling	Frost & Bolzan 1997:11
Agencies least likely to provide added services	Planned Parenthood affiliates and independent agencies	Frost & Bolzan 1997:11
Changes in the availability of such services in the 1990s	Few changes for most types of agencies, except for big increases for some services among Planned Parenthood affiliates	Frost & Bolzan 1997:11

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CHAPTER X
FUNDING OF SERVICES

Federal funding

Proportion of publicly funded agencies receiving some federal funds	96 percent	Frost & Bolzan 1997:12

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Federal programs providing such funds (and proportion of agencies receiving funds under each)	Medicaid (Federal/state)	91% of agencies	Frost & Bolzan 1997:12
	Title X, for family planning	60	
	Maternal/child health block grant	35	
	Social services block grant	15	
	Migrant/community health funding	15	

Federal/state Medicaid funding

How Medicaid supports family planning services	Through reimbursement for contraceptive services and supplies, as well as sterilization, with the Federal payment covering a mandated 90 percent of the amount and the State covering the remainder	Sollom et al. 1996:166
Limitations on Medicaid funding	Medicaid does not directly support establishment and operation of clinics and therefore does not cover many poor women not eligible for the program.	Kaeser et al. 1996:8

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Women receiving family planning services under Medicaid	2.2 million, or one in four women in the Medicaid program	Sollom et al. 1996:168
Total Medicaid expenditures on contraceptive services	$332 million in 1994	Sollom et al. 1996:168
Trend in Medicaid payments for contraceptive services	Upward, accounting by 1992 for 50 percent of such funding, versus 17 percent for Title X	Kaeser et al. 1996:8

Federal Title X funding

What is Title X	A federal program enacted in 1970 under the Public Health Service Act that provides family planning and closely related reproductive health services to over four million women	Kaeser et al. 1996:6
Relative importance of Title X	The largest source of federal support for family planning up to 1985, it is now surpassed by Medicaid. However, an unknown proportion of Medicaid payments for family planning services goes to private providers and managed care organizations rather than clinics.	Kaeser et al. 1996:8

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Whether Title X funds go only to state government agencies	No. Regional family planning councils, Planned Parenthood affiliates, and independent agencies also receive grants. (This is not the case for the next two Federal funding sources, the block grants.)	Sollom et al. 1996:166
Total Title X expenditures on family planning services	$151 million	Sollom et al. 1996:168
Trend in Title X funding	Downward to 1992, when, in constant dollars, funding was less than a third of 1980 funding; then slightly upward to 1994	Kaeser et al. 1996:25 Sollom et al. 1996:168

Federal block grants

What Federal block grants support family planning	Maternal/child health block grants Social services block grants	
Federal block grant funds spent for family planning services	$68 million	Sollom et al. 1996:169

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State and local funding

Proportion of agencies receiving state funding (other than Medicaid)	62 percent		Frost & Bolzan 1997:12
State funds spent on family planning services	$162 million		Sollom et al. 1996:168
Proportion receiving local funding	41 percent		Frost & Bolzan 1997:12

Private funding

Proportion of publicly funded family planning agencies also receiving some private funding	91 percent		Frost & Bolzan 1997:12
Sources of private funding (and proportion of agencies receiving each type of funding)	Client fees	88% of agencies	Frost & Bolzan 1997:12
	Private insurance	43	
	Private contributions	21	
	Norplant donations	16	

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Funding issues

Whether Title X recipients are more likely than other agencies to receive other types of funding also	Yes for all other types of funding except two: migrant or community health funding and private insurance payments	Frost & Bolzan 1997:12
Total state and federal funding for family planning services	$715 million	Sollom et al. 1996:168
Public funding per woman in need of subsidized family planning services	$47.50	
States reporting spending the most and the least per woman in need	New York ($95.50) and Louisiana ($10.30) (see Table)	

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Fees

Restrictions on fees under Title X	Clients whose family income is under the poverty level are not charged. Those whose family income is 100–250 percent of the poverty level are charged a reduced fee on a sliding scale.	Frost & Bolzan 1997:12
Fee charged for an initial exam, for clients whose income is 75 percent of the poverty level	No fee at three out of four agencies—but at only one out of three agencies that do not receive Title X funds. Where fees are charged, they are typically $20–30.	Frost & Bolzan 1997:13
Fee charged for an initial exam, for women with family incomes more than 2.5 times the poverty level.	$60–64	Frost & Bolzan 1997:13
Fee charged for a three-month supply of oral contraceptives	$10–15 for paying low-income clients, $22–24 for higher-income clients	Frost & Bolzan 1997:13

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Impact of public subsidies

Total number of unintended pregnancies averted by publicly funded services	4.1 million (from reversible methods only)	Forrest & Samara 1996:193
"Net" number of unintended pregnancies averted, when you assume that some clients would find other means to obtain services	1.3 million	Forrest & Samara 1996:192
Proportion of net averted pregnancies involving never-married women	Two out of three (but less than half of these women are teenagers)	Forrest & Samara 1996:192
How net pregnancies averted by public services compare with all unintended pregnancies not averted	Unintended pregnancies not averted are three times as many (see Figure 18)	Forrest & Samara 1996:193 and Kost & Forrest 1995:13

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Impact of clinics

Averted pregnancies attributable to family planning clinics	95 percent, the remaining 5 percent being attributable to physician services covered by Medicaid	Forrest & Samara 1996:192
Number of these pregnancies that would probably lead to births and to induced abortions	530,000 births 630,000 abortions	Forrest & Samara 1996:193
Resulting increase in the abortion rate	40 percent	Forrest & Samara 1996:193

Savings from public services

Public spending on contraceptive services	$412 million, FY87	Forrest & Samara 1996:193
Increases in public spending if unintended pregnancies were not averted	$1.2 billion additional under Medicaid to cover births and abortions	Forrest & Samara 1996:193

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Ratio of dollars saved from publicly subsidized family planning services to dollars spent on these services	3:1	Forrest & Samara 1996:193

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Major contraceptive methods	
Vasectomy (male sterilization)	Permanent method in which the vas deferens, through which the sperm travel from the testes to the penis, is blocked so that sperm can no longer enter the semen. A simple, minor procedure taking 5–10 minutes under local anesthesia.
Tubectomy, tubal ligation (female sterilization)	Permanent method in which the Fallopian tubes are blocked so that egg and sperm cannot meet. A relatively simple surgical procedure often done under local anesthesia. With a small incision in the abdomen (mini laparotomy) or a small puncture using a laparoscope (laparoscopy), tubes are cut and tied, clipped, or cauterized.
Implant	6 silastic tubes (Norplant®) inserted under the skin of a woman's upper arm slowly release the progestin levonorgestrel, which suppresses ovulation, thickens cervical mucus, and may thin endometrium. Effective for 5 years.
Injectable	Progestin injected intramuscularly, every 3 months (Depo-Provera™) or every 2 months (Noristerat™), suppresses ovulation, thickens cervical mucus, and sometimes thins endometrium.
Intrauterine device (IUD)	Small device in various shapes placed in the uterus induces an unsuitable environment for both sperm and eggs. Effective for 1 year (Progestasert™) or 4–8 years (copper-bearing IUDs).
Oral contraceptive pill	Pills taken daily in 21-day cycles combine synthetic female hormones estrogen and progestin or contain low doses of progestin only (minipill). Presence of hormones suppresses ovulation, thickens cervical mucus, and thins endometrium.
Condom	Latex (thin rubber) sheath placed on the erect penis

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	prevents sperm from entering the vagina. Female condom or vaginal pouch has recently become available.
Diaphragm, cervical cap	Soft rubber cup covers the cervix, used with spermicide in it to inactivate sperm. Cap is more compact and may be left in place 24 hours.
Spermicide	Foam, cream, jelly, tablet, or suppository, inserted into the vagina before intercourse, inactivates sperm and blocks entrance to the uterus. Effective about an hour, beginning 10–15 minutes after insertion.
Withdrawal	Penis is withdrawn from vagina before ejaculation.
Periodic abstinence	Couple refrains from sexual intercourse during fertile period of menstrual cycle, determined using a calendar, noting temperature rise after ovulation, or from amount and consistency of cervical mucus.
Lactational amenorrhea method (breastfeeding)	Full breastfeeding, with inability to conceive verified from amenorrheic status, ignoring bleeding before 56th day postpartum. For contraception, recommended only within 6 months postpartum.

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Reported annual public spending on contraceptive services per woman in need by state

$10-29	$30-39	$40-49	$50-59	$60-69	$70-95
Utah	Oklahoma	W. Virginia	Texas	Maryland	New York
Kansas	Washington	Mississippi	Missouri	Connecticut	Vermont
Nebraska	Hawaii	Mass.	Alabama	Delaware	N. H.
Alaska	Wisconsin	California	Kentucky	Florida	Maine
Colorado	Pennsylvania	Minnesota	N. Carolina	Nevada	Virginia
Idaho	N. Dakota	New Mexico	Wyoming	S. Carolina	
Indiana	Ohio	Oregon			
S. Dakota	D. C.	New Jersey			
Arizona	Tennessee	Montana			
Rhode I.	Iowa	Michigan			
Louisiana	Arkansas	Georgia			
	Illinois				

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Fig. 1. Percent using contraceptive methods, by age

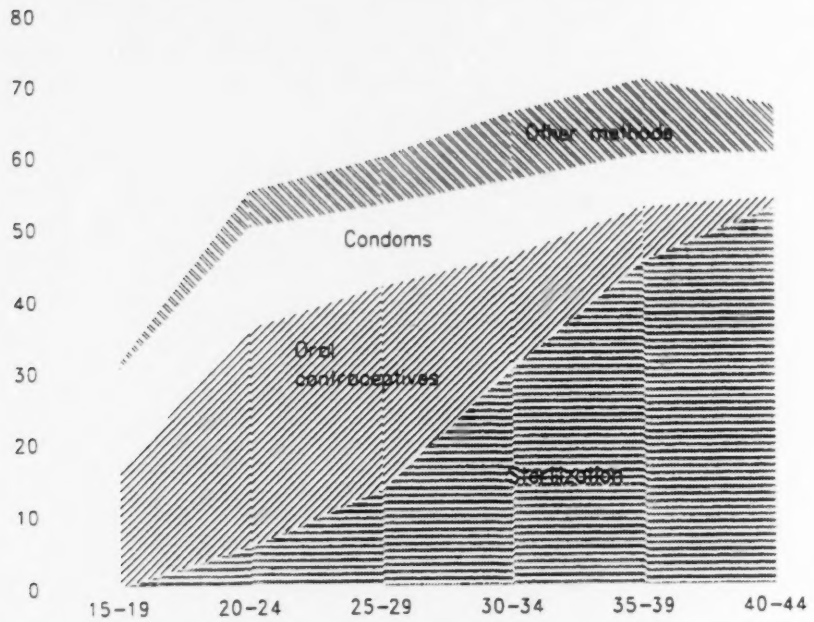

Fig. 2. Proportion sterilized among men aged 20–39 and their wives

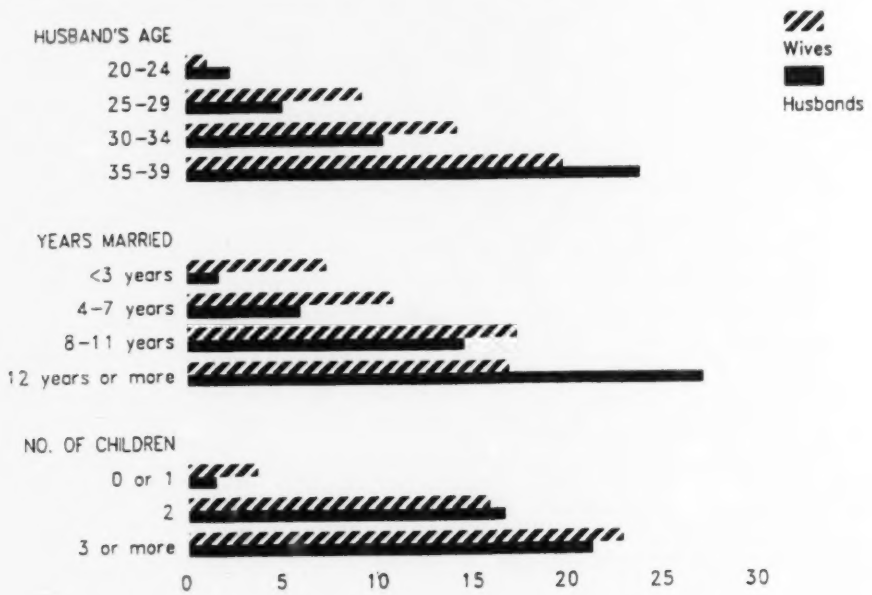

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Fig. 3. Percent relying on condoms, by woman's marital status

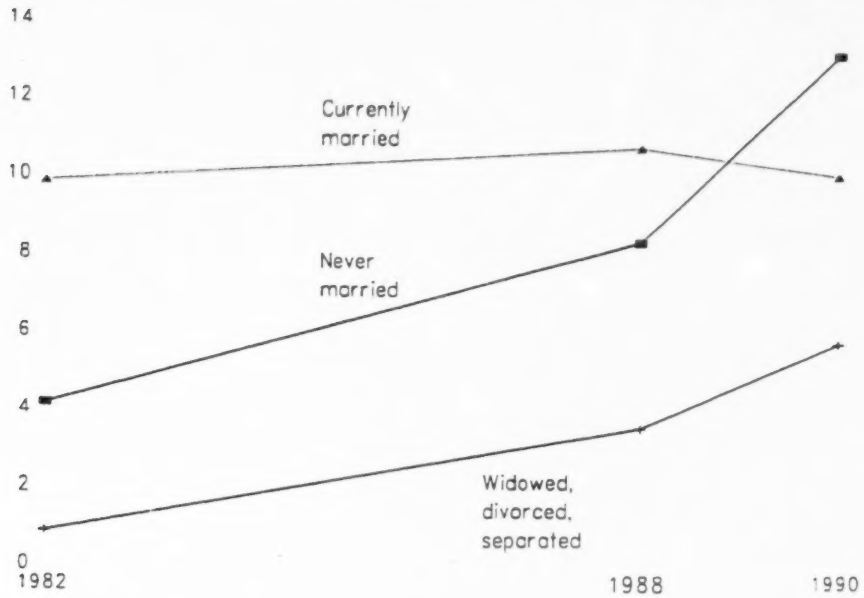

Fig. 4. Percent relying on condoms, by woman's age

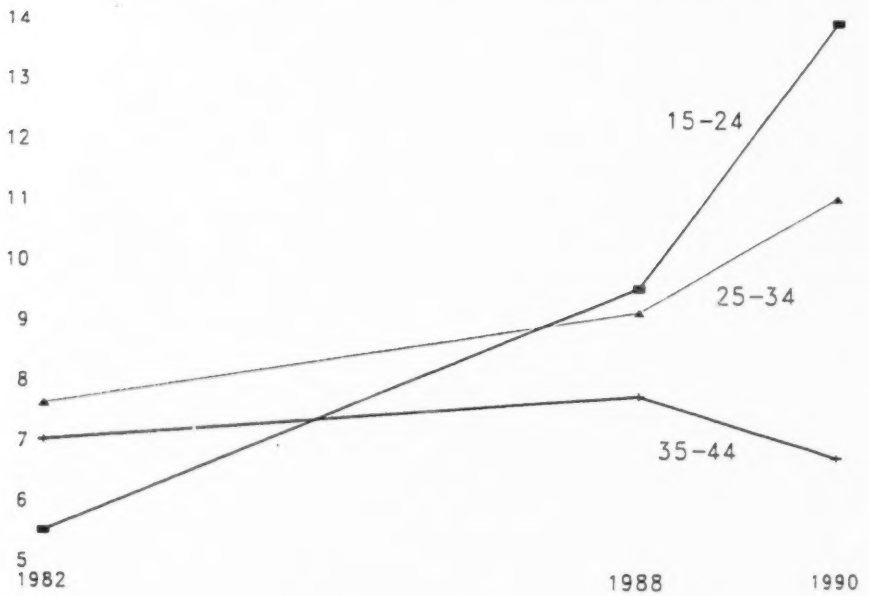

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Fig. 5. Method choice by income, shown as percent of the poverty line

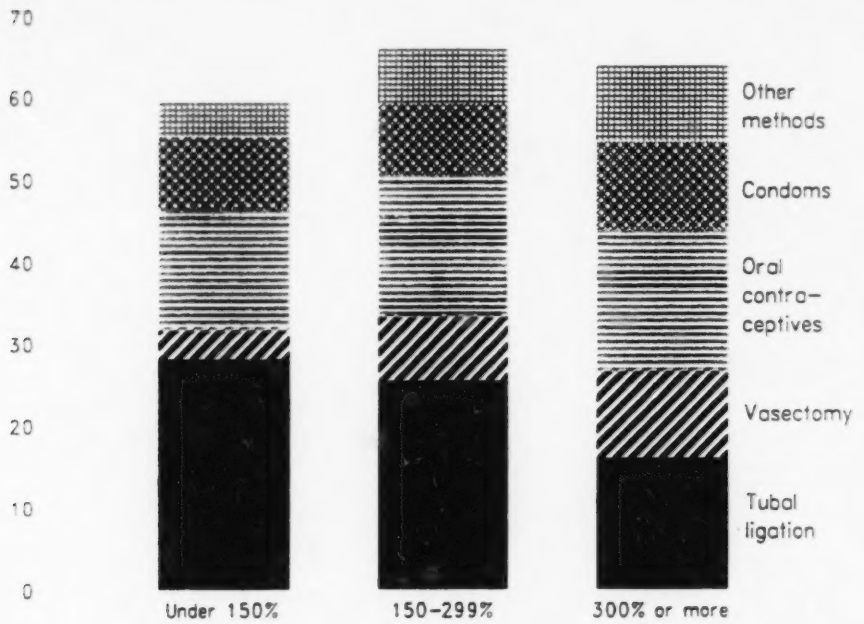

Fig. 6. Five-year cost of contracepting and not contracepting

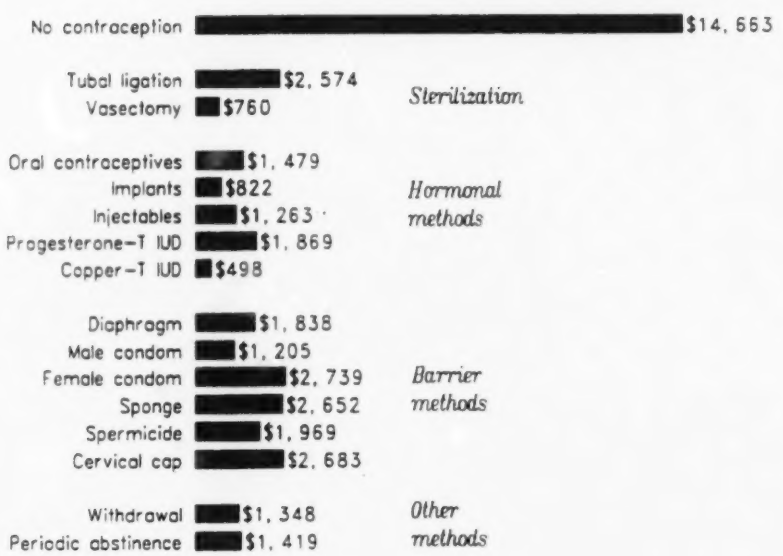

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Fig. 7. Trends in total fertility and crude birth rate

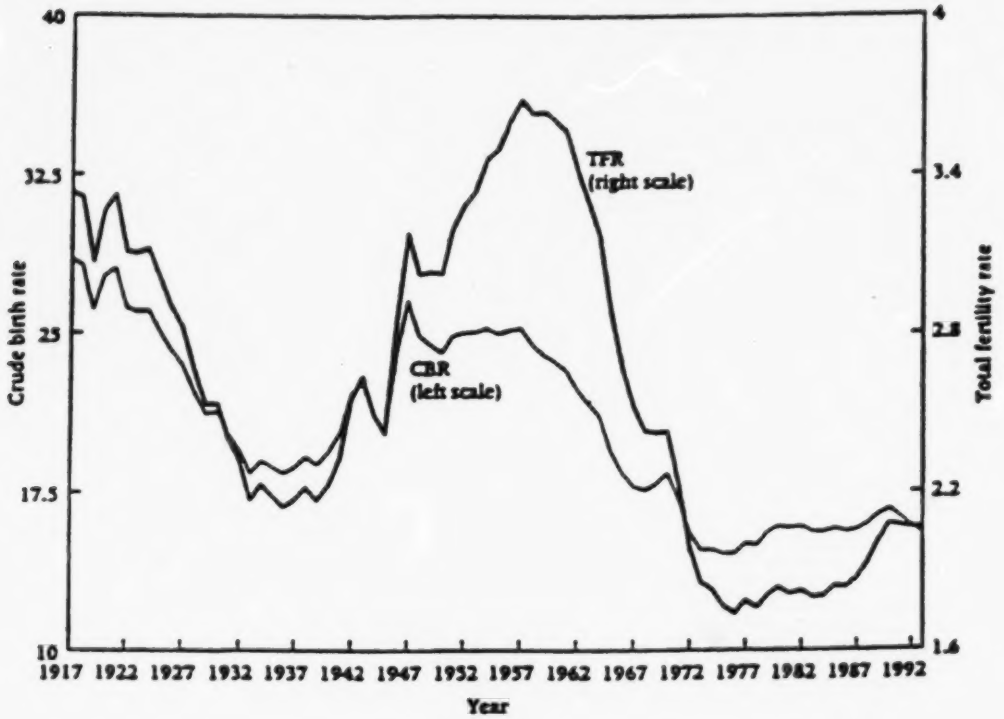

Fig. 8. Actual births and births expected for women by age in 1988

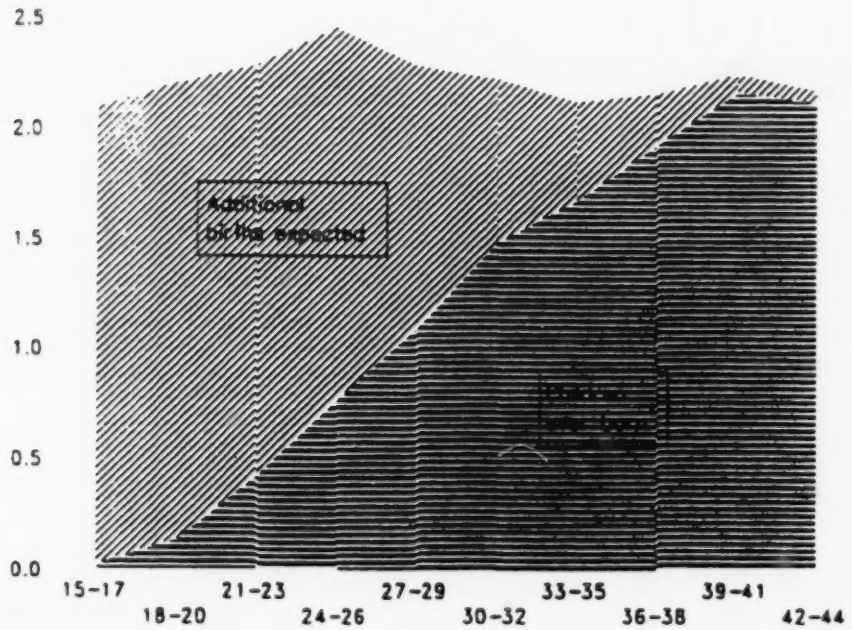

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Fig. 9. What is to blame for unplanned pregnancies: Adults' opinions

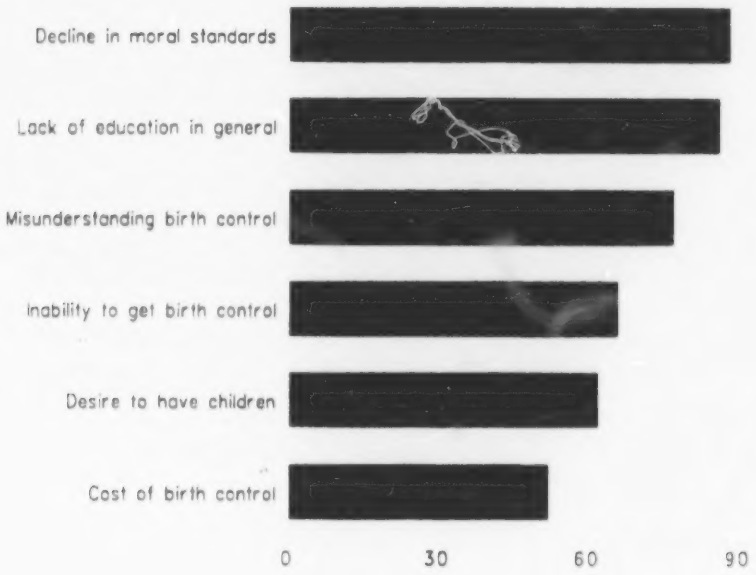

Fig. 10. Pregnancies per woman and their outcomes, by ethnic group

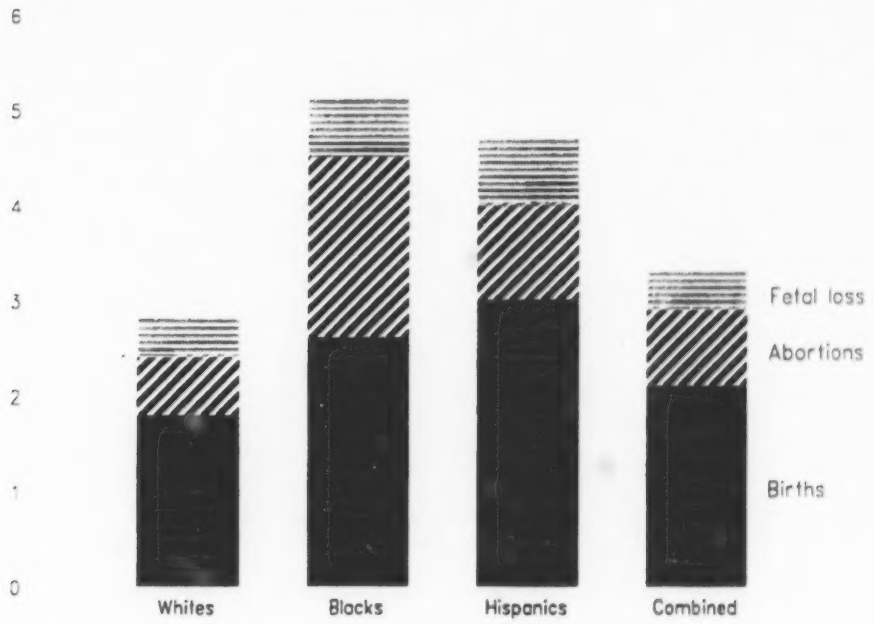

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Fig. 11. Births per thousand women, by age and ethnic group

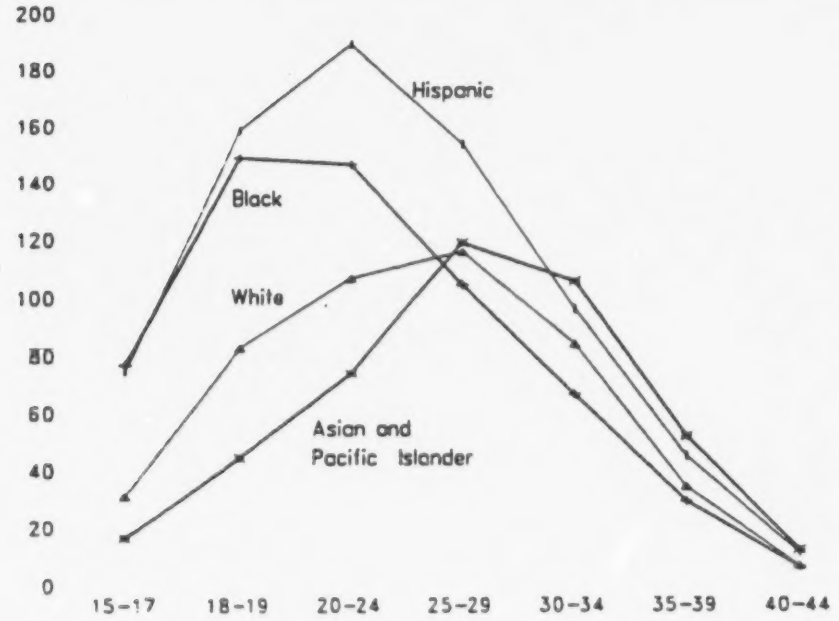

Fig. 12. Total fertility for Black and White women

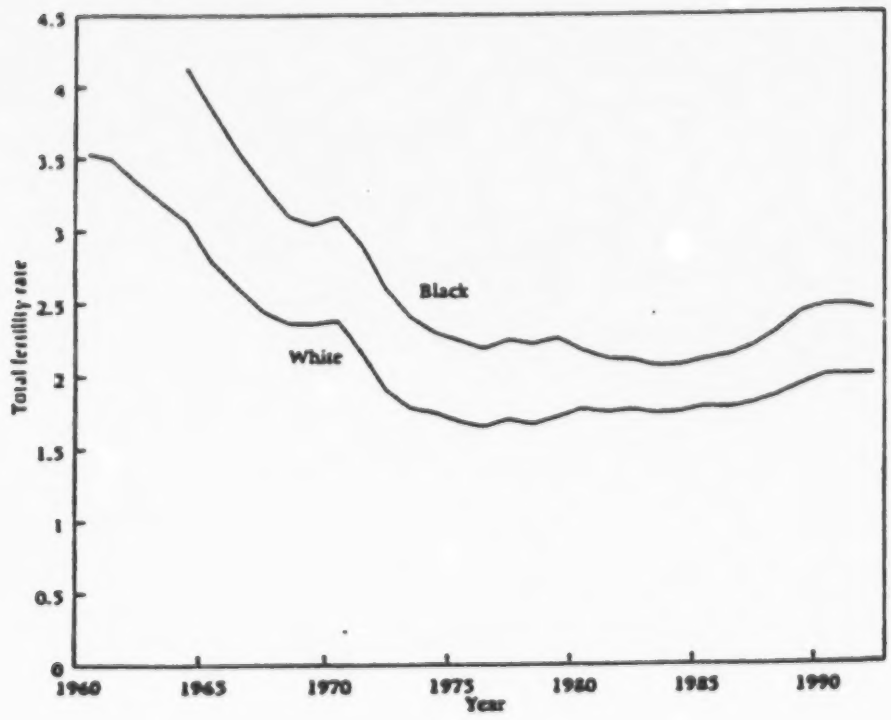

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Fig. 13. Births per thousand women, by age and education

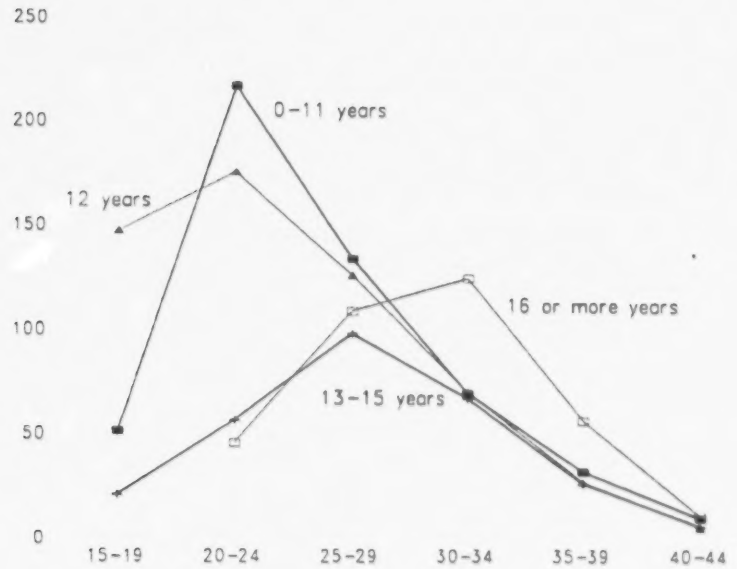

Fig. 14. Proportion of women working, and working with a young child

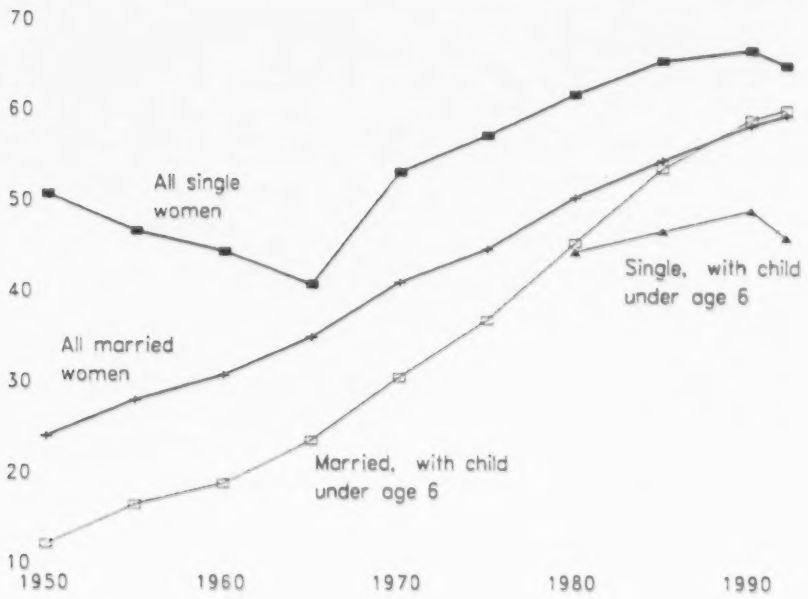

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Fig. 15. How clients pay physicians (percentages)

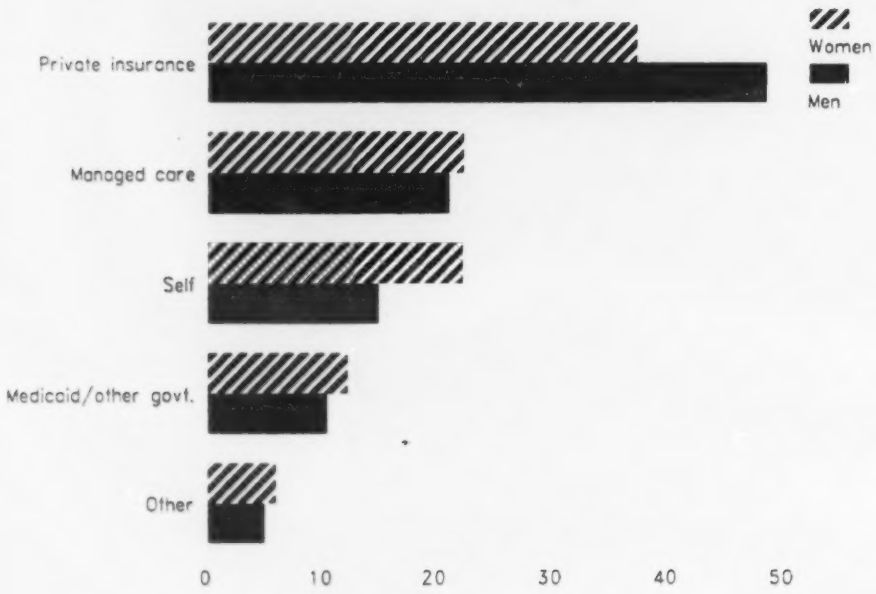

Fig. 16. Clinic size (based on clients) by agency and number of clinics

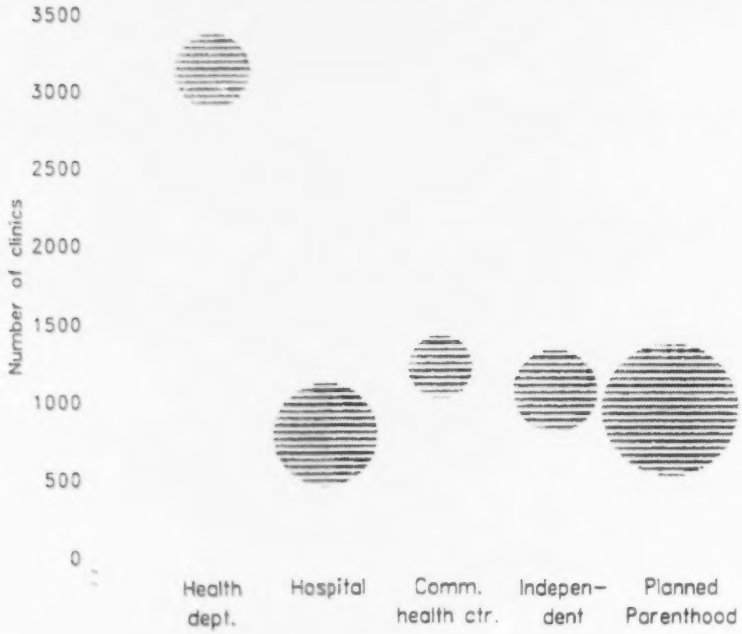

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Fig. 17. Percent of counties without family planning clinics, by state

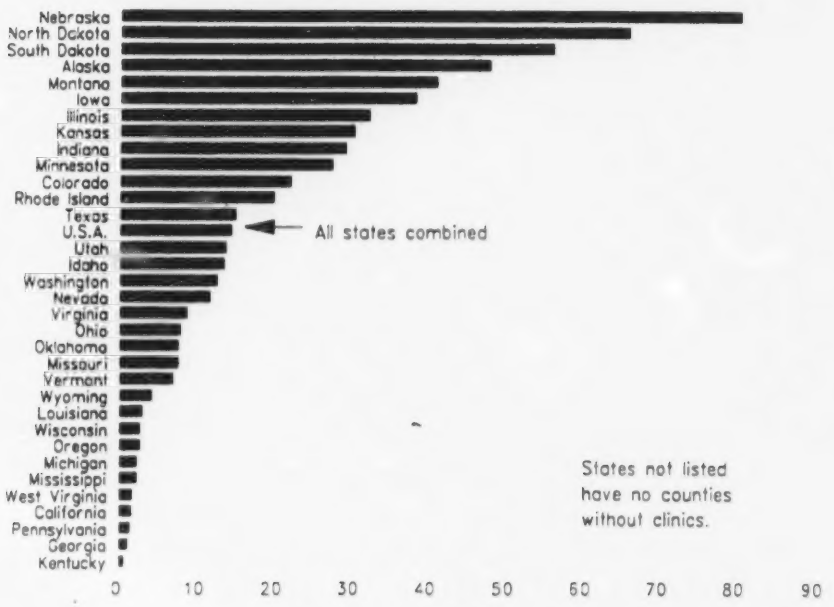
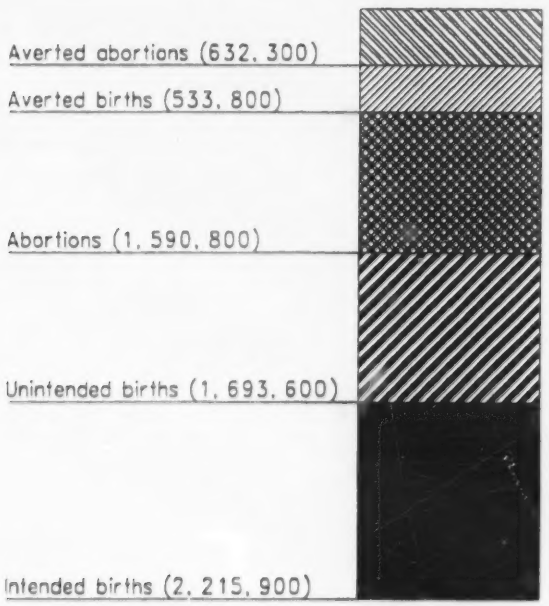


Fig. 18. Intended, unintended, and averted births and abortions


Averted abortions (632, 300)
Averted births (533, 800)
Abortions (1, 590, 800)
Unintended births (1, 693, 600)
Intended births (2, 215, 900)

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